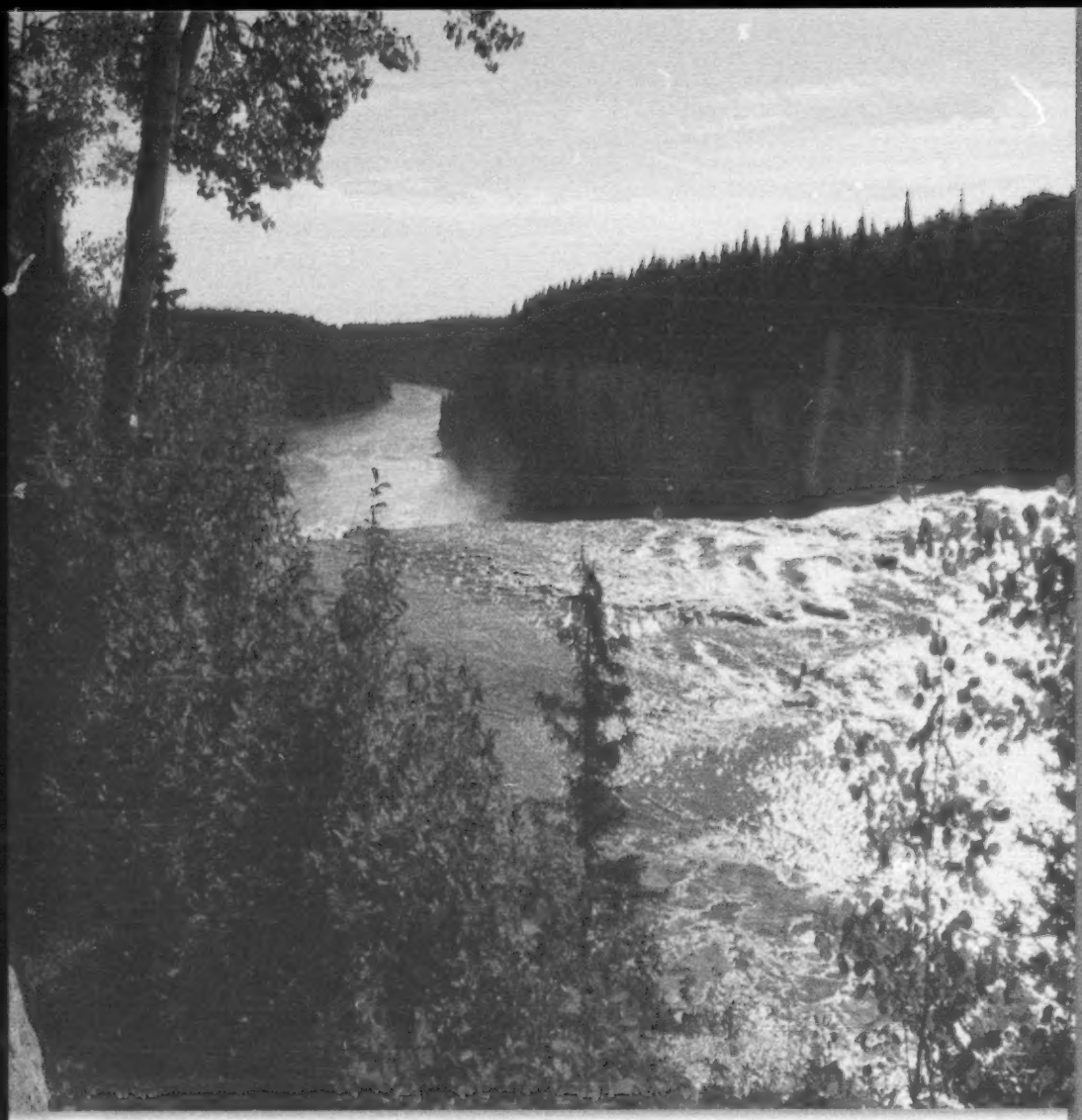

Government of Northwest Territories
Department of Health and Social Services
Continuing Care Review

Final - November 26, 2013

MNP LLP

Northwest Territories Health and Social Services

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Table of Contents

Glossary of Terms 1

1.0 Introduction 3

1.1 Continuing Care in the NWT 3
1.2 Background 3
1.3 Rationale for Review 7
1.4 Project Objectives and Scope 7

2.0 Approach and Methodology 9

2.1 Limitations 10

3.0 Current State of NWT's Continuing Care Programs and Services 11

3.1 Home and Community Care 11
3.2 Long-Term Care 33
3.3 Extended Care 45

4.0 Population Projections and Long-Term Care Bed Requirements to 2031 47

4.1 Population Projections for 70 Plus Age Group 47
4.2 Long-Term Bed Projections to 2031 in the NWT 49

5.0 Best Practice Research 56

5.1 Independent Living Supports 56
5.2 Restorative Approaches to Care 58

6.0 Conclusions 60

6.1 Home and Community Care 61
6.2 Long-Term Care 66
6.3 Extended Care 70

7.0 Recommendations 71

7.1 Recommendations for Entire Continuum of Care 72
7.2 Recommendations for Home and Community Care 75
7.3 Recommendations for Long-Term Care 82
7.4 Recommendations for Extended Care 85

8.0 Action Plan/Prioritized Recommendations 87

Appendix A: Interview and Focus Group Question Guides

Appendix B: Performance Measurement Best Practices and Critical Success Factors

Appendix C: Assumptions Underlying Home and Community Care Service Provider Mix Projections

Appendix D: Manitoba Health Guidelines for Home Care Tasks

List of Figures

Figure 1: NWT Continuing Care Framework Model 4
Figure 2: NWT Continuum of Care Levels of Service Graphic 5
Figure 3: Project Approach 9
Figure 4: Number of Clients by HSSA from 2010/11 to 2012/13 14
Figure 5: Total HCC Service Hours by HSSA from 2010/11 to 2012/13 15
Figure 6: Breakdown of 2012/13 Home and Community Care Funding by HSSA 23
Figure 7: Breakdown of 2012/13 Home and Community Care Funding by HSSA 24
Figure 8: NWT Palliative Care Logic Model 32
Figure 9: Map Showing Current Distribution of LTC Beds 34
Figure 10: Occupancy of LTC Facilities in the NWT in 2011/2012 and 2012/13 36
Figure 11: Average Age of Residents Occupying Beds in LTC Facilities in the NWT 37
Figure 12: Average Length of Stay of Residents in LTC Facilities in the NWT 37
Figure 13: Average Level of Care of Residents Occupying Beds in LTC Facilities in the NWT 38
Figure 14: Growth Trends used in Developing Population Projections to 2031 47
Figure 15: Projected Population Growth Trends for 70 plus Age Group by HSSA 48
Figure 16: Projected Population Growth Trend for Yellowknife HSSA and NWT 49
Figure 17: Map Showing LTC Bed Requirements for each Region 52
Figure 18: Framework for Recommendations to Continuing Care Services in the NWT 71
Figure 19: Projected Mix of Nursing and HSW staff to the Year 2031 79
Figure 20: Projected LTC Bed Requirements in the NWT to the Year 2031 83

List of Tables

Table 1: Population Growth by Age Group from 2001 to 2012 6
Table 2: Summary of Key Informant Consultations 10
Table 3: Comparison of HCC Services and Number of Clients by HSSA 12
Table 4: Age Distribution of HCC Clients by HSSA from 2010/11 to 2012/13 15
Table 5:Total Number of Hours of Service by Client Type for each HSSA 16
Table 6:Total Number of Hours of Service by Activity for each HSSA 17
Table 7: Staffing Levels and Service Provider Mix by HSSA 19
Table 8: HCC Funding and Spending 22
Table 9: Inventory of Independent Housing Units Targeted for Elders and Persons with Disabilities 25
Table 10: Inventory of Respite Beds in NWT 29
Table 11: Current Stock of LTC Beds in the NWT 33
Table 12: Placement Data by Facility from 2009/10 to 2012/13 40
Table 13: Summary of Assessed Level of Care by the TAC 40
Table 14: Summary of Assessed Care Type by the TAC 41
Table 15: Current and Proposed Hours of Direct Care for LTC Facilities 42
Table 16: Current and Proposed Staffing Levels for NWT LTC Facilities 43
Table 17: LTC Facility Funding and Actual Funding 43
Table 18: Occupancy of Stanton ECU Beds 45
Table 19: Admissions to Stanton ECU 46
Table 20: Staffing Mix of Stanton Extended Care Unit 46
Table 21: Population Projections for the 70 plus Age Group in each HSSA to 2031 48
Table 22: LTC Bed Ratio per 1,000 Population Aged 70 Plus for each Projection Method 50
Table 23: Projected LTC Bed Requirements for each HSSA 51
Table 24: Total Projected Need for LTC Beds in the NWT 54
Table 25: Projected Need for Dementia Beds in the NWT 55
Table 26: Projected Need for Extended Care Beds in the NWT 55
Table 27: Summary of Service Provider Mix by HSSA in 2012/13 (FTE Staff) 61

Table 28: Ratio of HCC Service Providers per 100 HCC Clients 62
Table 29: LTC Bed Demand in 2011 by HSSA 67
Table 30: Projected LTC bed surplus/deficit in each HSSA 68
Table 31: Proposed Single Point of Entry Region Size and Activity 76
Table 32: Comparison of Existing HSSA Staffing to Projected Service Provider Mix for the Present 78
Table 33: Priority of Recommendations 87

Glossary of Terms

BDHSSA – Beaufort Delta Health and Social Services Authority

CCAP - Continuing Care Assessment Package

CHMIS – Community Health Management Information System

CHN – Community Health Nurse

Department – Department of Health and Social Services

DHSSA – Dehcho Health and Social Services Authority

ECU – Extended Care Unit

FNIHB – First Nations and Inuit Health Branch

FSHSSA – Fort Smith Health and Social Services Authority

FTE – Full-Time Equivalent

GNWT – Government of Northwest Territories

HCC – Home and Community Care

HRHSSA – Hay River Health and Social Services Authority

HSSA – Health and Social Service Authority

HSW – Home Support Worker

LOC – Level of Care

LOS – Length of Stay

LPN – Licensed Practical Nurse

LTC – Long-Term Care

NGO – Non-Government Organization

NIC – Nurse in Charge

NWT – Northwest Territories

NWTDC – NWT Disabilities Council

NWTHC – NWT Housing Corporation

OT – Occupational Therapy

PSW - Personal Support Worker

PT – Physiotherapy

RAI-HC - Inter-RAI Home Care

RCA – Resident Care Aide

RCC – Referral Care Coordinator

RN – Registered Nurse

SHSSA – Sahtu Health and Social Services Authority

SL - Supported Living

STHA – Stanton Territorial Health Authority

TAC – Territorial Admissions Committee

TCSA – Tlicho Community Services Agency

YACL - Yellowknife Association of Community Living

YHSSA – Yellowknife Health and Social Services Authority

1.0 Introduction

1.1 Continuing Care in the NWT

Continuing Care is a core service of the Northwest Territories (NWT) Department of Health and Social Services (Department) that is delivered through three program streams including:

- Home and Community Care (HCC);
- Supported Living (SL); and
- Long-Term Care (LTC) and Extended Care.

Continuing Care refers to those services that maintain or improve the physical, social, and psychological health of Elders and individuals who for a variety of reasons may not be able to fully care for themselves. The goal of continuing care is to improve independence and quality of life for Elders and their families[1]. Community inclusion and full participation in cultural activities is valued. The services are delivered to NWT residents of all ages, in their homes, or other places of residence such as group homes, assisted living apartments, independent seniors housing units and in a small number of facilities, such as LTC, generally located in regional centres. Continuing care also includes acute care nursing services related to early discharge from the hospital.

Continuing Care services are:

- Part of a continuum of health and social services provided by Regional Health and Social Services Authorities (HSSA);
- Delivered using a team approach that involves inter-program collaboration with primary care, public health, rehabilitation services, and other community agencies and resources; and
- Complemented by respite, palliative care and adult day services.

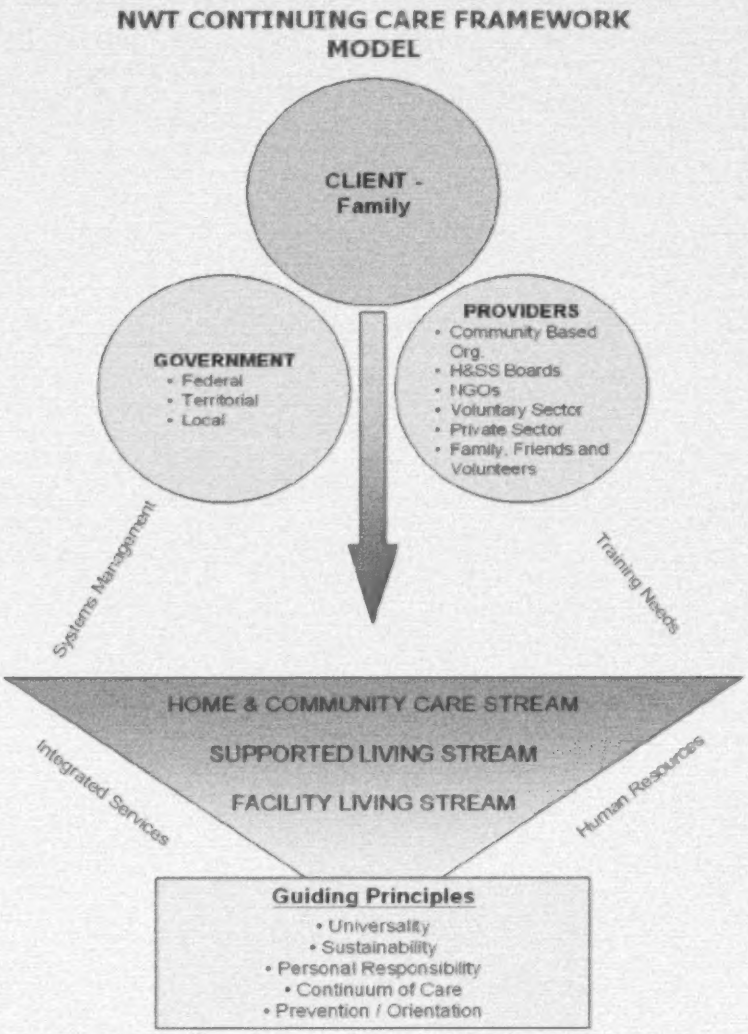
1.2 Background

Continuing Care services delivered in the NWT are guided by the Continuing Care Framework Model, which was developed in 2002 and updated in 2008 to illustrate the current model for service delivery (Figure 1). The model illustrates the importance of the client and family within Continuing Care service delivery and the range of service providers involved in the delivery of continuing care.

Since the Continuing Care Framework Model was developed, the Department has adopted Supportive Pathways, a care philosophy that was developed by Carewest in Calgary Alberta, as the approach to caring for individuals with dementia. Supportive Pathways uses a person-centered philosophy of care to support individuals with a wide range of physical, emotional and cognitive challenges and assets. Supportive Pathways recognizes that each individual has a unique journey through the disease process; It incorporates skilled staff, specially designed environments, and a partnership with families to provide individuals with the highest quality of life possible. Staff training in Supportive Pathways is provided, which incorporates the latest research knowledge and best practices in dementia care. The Department is working to finalize DRAFT Continuing Care Standards, which will also guide the delivery of HCC, SL, and LTC programs and services.

[1] Integrated Service Delivery Model. Northwest Territories Department of Health and Social Services. March 2004.

Figure 1: NWT Continuing Care Framework Model[2]

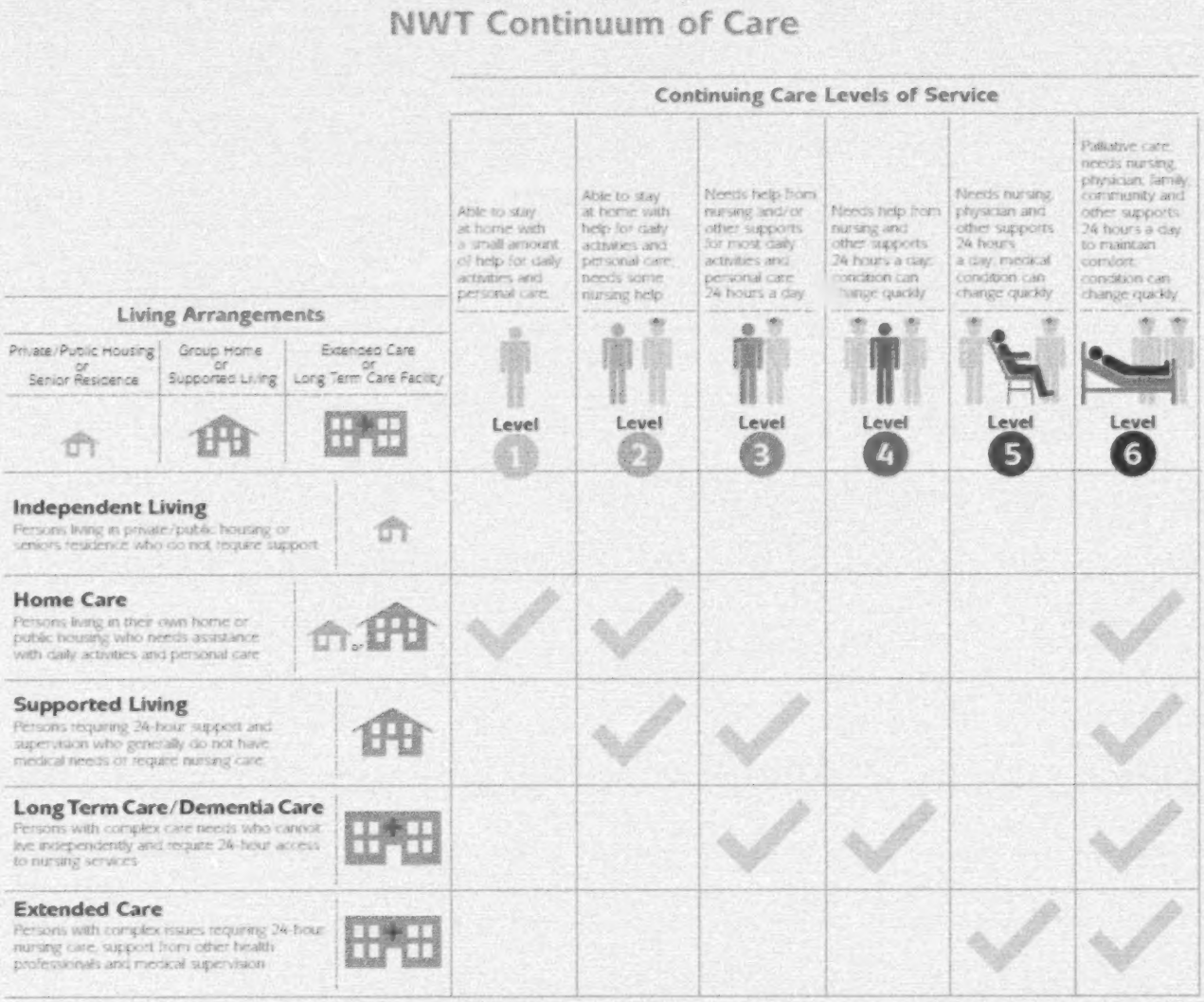


Presently, and for many years, Continuing Care has relied upon the Continuing Care Assessment Package (CCAP) as the standard assessment tool. The CCAP supports decisions related to client access to services across the continuum of care - home care; supported living and long-term care. The CCAP is lengthy and lacks credibility in regard to evidence based decision support. In recent years Inter-RAI has been implemented in most Canadian jurisdictions and is the standard tool being used for homecare service decisions and data collection nationally and internationally. The Department completed a business case for InterRAI in 2009/10 that confirmed it is the recommended assessment tool for continuing care services in home care and long term care, however has not yet been able to secure capital funding to implement InterRAI.

[2] Continuing Care Framework Document. Prepared by the Department. April 2008.

Once an assessment is completed, an individual's care needs are categorized according to NWT Levels of Care. The Levels of Care describe functional characteristics categorizing individuals into care levels to support decision-making about appropriate support services and care across the continuum (e.g. individuals requiring Level 3 or 4 care are eligible for admission into LTC). The NWT Levels of Care were revised and approved for implementation July 2012. Recently, the Levels of Care have been integrated into a Continuum of Care Levels Graphic (Figure 2), for use as a communication tool when discussing integration of Continuing Care service with other community based services.

Figure 2: NWT Continuum of Care Levels of Service Graphic[3]


NWT Continuum of Care
Continuing Care Levels of Service
Able to stay at home with a small amount of help for daily activities and personal care
Able to stay at home with help for daily activities and personal care; needs some nursing help
Needs help from nursing and/or other supports for most daily activities and personal care 24 hours a day
Needs help from nursing and other supports 24 hours a day; condition can change quickly
Needs nursing, physician and other supports 24 hours a day; medical condition can change quickly
Palliative care; needs nursing, physician, family, community and other supports 24 hours a day to maintain comfort; condition can change quickly
Living Arrangements
Private/Public Housing or Senior Residence
Group Home or Supported Living
Extended Care or Long Term Care Facility
Level 1
Level 2
Level 3
Level 4
Level 5
Level 6
Independent Living
Persons living in private/public housing or seniors residence who do not require support
Home Care
Persons living in their own home or public housing who needs assistance with daily activities and personal care
Supported Living
Persons requiring 24-hour support and supervision who generally do not have medical needs or require nursing care
Long Term Care/Dementia Care
Persons with complex care needs who cannot live independently and require 24-hour access to nursing services
Extended Care
Persons with complex issues requiring 24-hour nursing care, support from other health professionals and medical supervision

[3] Provided by the Department.

All NWT residents are eligible to receive Continuing Care services, however, as in many Canadian jurisdictions, the majority of Continuing Care services are used by Elders (who are defined as 60 years and over in the NWT). This population tends to experience loss in function due to the prevalence of chronic diseases, injury, and illness.

1.2.1 Demographics and Health Status

In 2012, it was estimated that there were approximately 4,616 people aged 60 and over in the NWT, which represented approximately 10.6% of the total estimated territorial population of 43,349.[4] From 2001 to 2012, the 60 plus age group grew 82.5%, significantly more than any other age group in the NWT (Table 2). In addition, the 60 plus age group is projected to grow significantly more than any other age group by the year 2031 (Section 4.0).

Table 1: Population Growth by Age Group from 2001 to 2012

NWT Overall	Under 16	15 to 44	45 to 59	60 & Over
6.1%	-14.5%	-0.5%	31.0%	82.5%

The following section highlights findings from the 2011 NWT Health Status Report regarding the health status of people aged 60 and over in the NWT. The report found that:[5]

- 70% of those aged 65+ self-rated their health status as good, lower than each of the other age demographics.
- The 65-75 age group had the highest self-rating for having "quite a lot of stress".
- The prevalence of diabetes was 21.6% in the 75+ age group and 20.2% in the 60-74 age group, more than double than any other age group.
- The incidence of cancer was approximately three times higher for females and four times higher for males in the 65+ age group.
- The prevalence of arthritis and rheumatism was 55%, significantly higher than any other age group.
- The prevalence of high blood pressure was 8% for the 65+ age group, significantly higher than any other age group.
- The incidence rate of Tuberculosis was 9.9 per 10,000 for the 60+ age group, significantly higher than any other age group.
- The hospitalization rate for mental illness for the 65+ age group was 317 per 10,000, significantly higher than any other age group.

The 2013 NWT Hospitalization Report found that for elders aged 65 and older:

- The possibility of being hospitalized, and the related cost of hospitalization, increases with age.
- The top five conditions that were the primary causes for the hospitalization of two thirds of the patients aged 65 and older included circulatory conditions, respiratory conditions, digestive system diseases, cancers and injuries. These conditions resulted in 70% of the estimated hospital costs for this age group.
- Modifiable risk such as poor diet, inactive lifestyle, smoking and long term alcohol abuse contribute to diseases of the heart and veins that can lead to heart attacks and strokes.

[4] Based on population estimates from the NWT Bureau of Statistics.
[5] Northwest Territories Health Status Report. August 2011.

- Falls accounted for the majority of resources for injury hospitalizations of people aged 75 and older.

With the trend for faster repatriation to community from hospitals and early discharge patterns there is increasing need for care in the home to support convalescence or gradual restoration of health after illness or injury. Individuals have more intense resource needs due to the acuteness of their health status. Alberta Health's 48 hour notice of repatriation to the NWT (policy of Referral, Access, Advice, Placement, Information and Destination - RAAPID) is a reminder of the pressures that external forces can exert on the NWT health and social services system.

1.3 Rationale for Review

A number of factors have impacted the need for Continuing Care programs and services including:

- An increase in the population of adults over the age of 60 in the NWT which has resulted in increased utilization of HCC services and occupancy of acute care beds, LTC beds, and extended-care beds across the territory;
- An increase in the number of individuals with some degree of dementia;
- A need for HCC in small communities to support family caregivers and encourage residents to remain in their home communities as long as possible;
- An increase in the number of Elders and families wishing to be cared for in their home and community at end-of-life; and
- Changing approaches to hospital care including an increase in rapid discharge which has increased demand for acute HCC services.

The Department has identified a need to be ready to respond to the growing demand for Continuing Care services. A LTC Planning Study was completed in the 2009/10 fiscal year and recommended that the Department update the projected requirements for LTC beds within 5 years. Further, one of the top priorities of the Department's Strategic Plan, *Building on our Foundation 2011-2016*, is to strengthen the delivery of core services in the community as it is important to realizing efficiencies and improving outcomes.

With this in mind, the Department contracted MNP_{LLP} (MNP) a Chartered Accounting and Consulting firm to review the delivery of Continuing Care services across the NWT.

1.4 Project Objectives and Scope

The overall objective of this project was to review Continuing Care Services and provide evidence to support the development of an updated Continuing Care strategy that will ensure services meet the needs of Elders and individuals with disabilities who require support to achieve their desired quality of life. The review is intended to provide a description of the current state of services in the NWT, including strengths and gaps in HCC, LTC, palliative care and community capacity and includes the following elements:

- Recommendations for strengthening HCC services at the community level, based on the analysis of demographics, best practice, and health status. This includes:
    - Recommendations on service provider mix;
    - Recommendations on scope of services that can be provided based on community size and capacity;

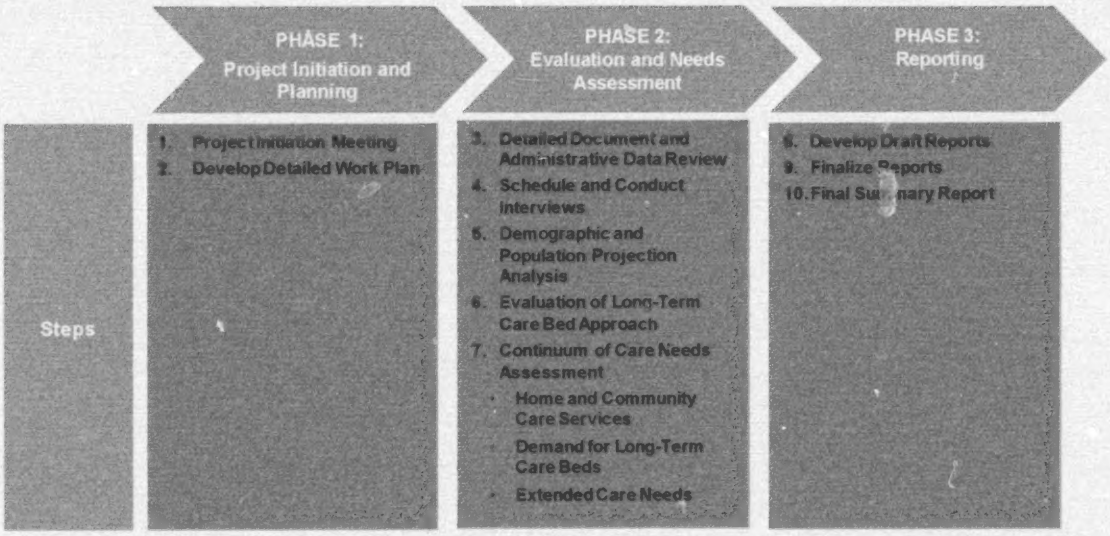
  - Recommendations on service limits for nursing, home support and homemaker functions; and
  - Recommendations for infrastructure and supports that will allow Elders in smaller communities to remain in their home and/or communities longer.

- Updating the projected demand for LTC beds based on the population projection for those 70+ to confirm the current and future requirements for long term care beds within the NWT and projecting the need for services such as in facility respite, palliative care, geriatric assessment and consult service (geriatrician, OT/PT/SLP/SW), and restorative care.
- Reviewing and proposing any required revisions to the Department's current philosophical approach to treating LTC beds as a territorial resource; including an assessment of the success of this approach since the Territorial Admissions Committee was established.
- Reviewing the services required by the NWT regarding Extended Care beds needed presently and into the future within the NWT.
  - Planning recommendations for Extended Care beds, staffing model (hours of direct care, mix and ratio) and appropriate location of beds.

2.0 Approach and Methodology

Figure 3 summarizes the approach that was taken to complete project work. Project work was structured into three distinct, but linked phases. Each phase had distinct steps and outcomes.

Figure 3: Project Approach


PHASE 1:
Project Initiation and Planning
PHASE 2:
Evaluation and Needs Assessment
PHASE 3:
Reporting
Steps
1. Project Initiation Meeting
2. Develop Detailed Work Plan
3. Detailed Document and Administrative Data Review
4. Schedule and Conduct Interviews
5. Demographic and Population Projection Analysis
6. Evaluation of Long-Term Care Bed Approach
7. Continuum of Care Needs Assessment
- Home and Community Care Services
- Demand for Long-Term Care Beds
- Extended Care Needs
8. Develop Draft Reports
9. Finalize Reports
10. Final Summary Report

Data, informing analysis and ultimately development of the report was collected using the following methods:

- Detailed review of background documentation and administrative data provided by the Department and the NWT Bureau of Statistics;
- Key informant consultations including interviews and focus groups (Table 1); and
- Best practice research including online research and discussions with representatives from other jurisdictions.

The following administrative data sets were included as a part of the review:

- NWT Bureau of Statistics population projections to 2031
- Health Suite Total Services Reports
- HCC staffing levels
- HCC budgets
- Detailed LTC utilization data by facility
- Consolidated LTC utilization data
- LTC budget data
- LTC staffing level data
- Territorial Admissions Committee (TAC) placement and waitlist data

- Health and Social Service Authority (HSSA) main estimate staffing data
- First Nations and Inuit HCC funding contribution agreements
- Independent housing inventory data
- Respite Services Evaluation Report

Table 1 summarizes the key informant consultations that were conducted during the project. MNP conducted 17 interviews and 3 focus groups. The question guides used for the consultations are included in Appendix A.

Table 2: Summary of Key Informant Consultations

Key Informant Group	Number of Interviews/Focus Groups
Department Senior Management and Staff	9 interviews
Health and Social Service Authority CEOs	7 interviews
Avens a Community for Seniors	1 Interview
Continuing Care Managers and Directors	1 focus group (13 participants)
Continuing Care Nursing Staff	1 focus group (7 participants)
NWT Housing Corporation/Department Representatives	1 focus group (7 participants)

2.1 Limitations

As with all projects, there were limitations that impacted the evaluation of Continuing Care services. Namely:

- The NWT Bureau of Statistics population projection data was only available to the year 2031. Therefore, the LTC bed requirements for the NWT were projected to 2031 rather than 2035.
- The financial information provided for HCC and LTC did not include sufficient detail to determine costing associated with the recommendations made in Section 7.0.
- The Health Suite data provided included activity data (number of HCC cases, admission/ discharge activity and hours of service) at the HSSA level, but not at the community level. This limited the ability to make recommendations for HCC service provider mix and scope of services at the community level.

3.0 Current State of NWT's Continuing Care Programs and Services

The sections that follow describe the current state of HCC and LTC programs and services including extended care, respite and palliative care, and adult day programs in the NWT. This analysis provides the foundation from which recommendations for Continuing Care Services in the NWT were made.

3.1 Home and Community Care

The responsibility for the delivery of the Home and Community Care (HCC) program in the NWT has been delegated to the HSSAs.

The objectives of HCC in the NWT are:

- To enable any person with a medical or chronic care problem, or who is at risk of developing one, to be admitted to the HCC program.
- To make available to Northerners, a broad range of home and community care services including: respite care, palliative care, chronic care, foot care, medications management, wound care, home management, ambulation, post hospital/early discharge follow up, social support, meals on wheels, transportation assistance and equipment loan. In the larger centers other components may also include home IV therapy, and cardiac rehabilitation.
- To provide services by one or a combination of the following professionals: physician, registered nurse, licensed practical nurse, physiotherapist, occupational therapist, speech language pathologist, community health representative, home support worker, personal care attendant, or medical social worker.

What follows is a description of the HCC programs and services and service provider mixes available in each HSSA, funding model and levels for HCC, a description of complimentary services including respite care, palliative care, and adult day programs, and key informant perceptions regarding HCC in the NWT.

3.1.1 Inventory of Existing Staff Mix and HCC Programs and Services

The availability of HCC services is dependent on the size of each community and the resources that exist. A comparison of the HCC services available, the population of Elders aged 60 and over, and the number of HCC clients in each HSSA is provided in Table 3.

Table 3: Comparison of HCC Services and Number of Clients by HSSA

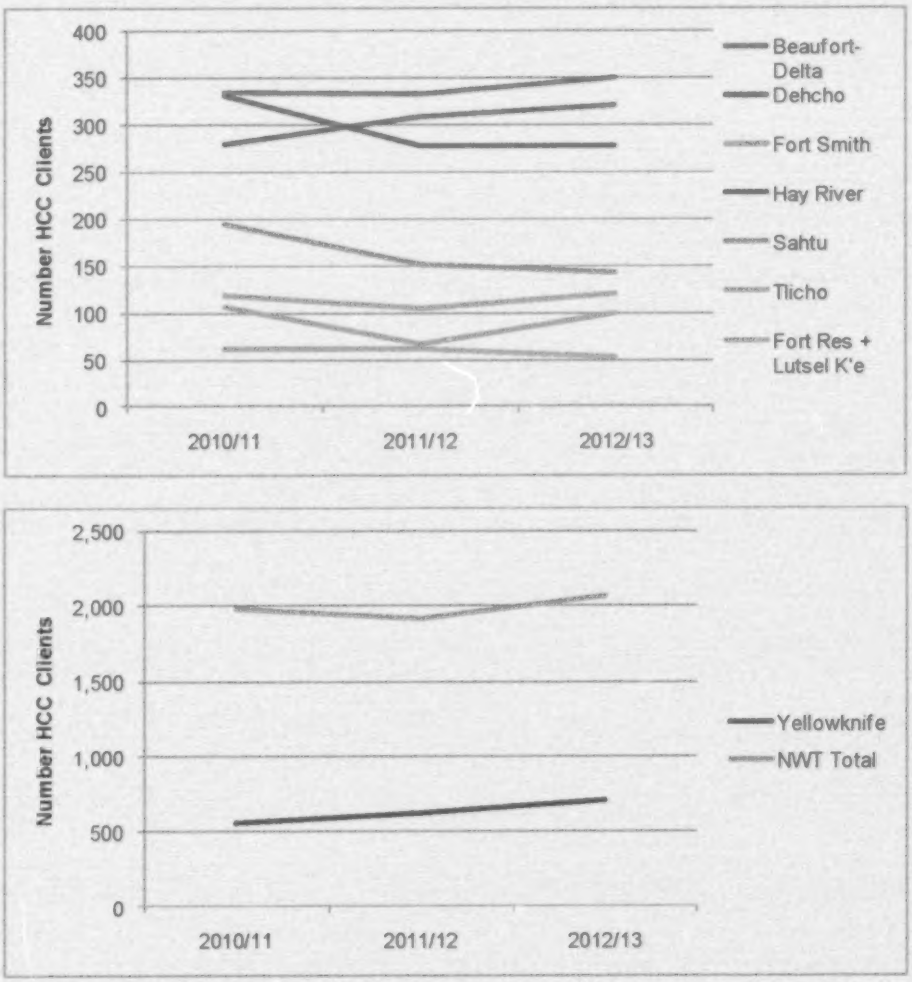
HSSA	HCC Services[6]	60 Plus Population (2011)[7]	Number of HCC Clients[8]
Beaufort-Delta	• Home management, personal care, equipment loans, caregiver support and education, Elder day programs, nursing care, meal services, transportation services, case assessment and coordination, in-home respite and palliative care. • Extended HCC services in Aklavik (12 hours per day Monday to Friday and 7.5 hours on weekends).	767	2010/11 - 335 2011/12 - 333 2012/13 - 351
Dehcho	• Home management, personal care, transportation services, medication delivery and compliance, translation services, assistance with participating in recreational and traditional activities, assistance with skills required for daily living, case assessment and coordination in-home respite and palliative care.	356	2010/11 - 279 2011/12 - 308 2012/13 - 320
Fort Smith	• Home management, personal care, meal services, nursing services, foot care, case assessment and coordination, care for acute post-hospital clients, and palliative care.	354	2010/11 - 119 2011/12 - 105 2012/13 - 121
Hay River	• Home management, personal care, nursing services, foot care, education, case assessment and coordination, care for post-hospital clients, in-home respite and palliative care.	510	2010/11 - 331 2011/12 - 278 2012/13 - 277
Sahtu	• Home management, personal care, nursing care, meal preparation, supportive services, case assessment and coordination, medication delivery/ administration, health promotion, care for acute post-hospital clients, translation services, foot care, Elder social programs, in-home respite care and palliative care.	240	2010/11 - 194 2011/12 - 151 2012/13 - 143

[6] Based on the 2012/13 FNIHCC contribution funding agreements for each HSSA.
[7] Based on data provided by the NWT Bureau of Statistics.
[8] Based on data in the Health Suite Total Services Report for each HSSA in 2010/11, 2011/12 and 2012/13.

HSSA	HCC Services[6]	60 Plus Population (2011)[7]	Number of HCC Clients[8]
Tlicho	• Home management, personal care, nursing care, meal services, foot care, case assessment and coordination, rehabilitation services, in-home respite and palliative care.	227	2010/11 - 106 2011/12 - 67 2012/13 - 99
Yellowknife (Yellowknife, Dettah and N'Dilo)	• Home management, personal care, nursing care, meal services, case assessment and coordination, education, health promotion and prevention, medication management, care for acute post-hospital clients, foot care, shopping, rehabilitation services, enterostomal therapy, in-home respite and palliative care.	1,565	2010/11 - 553 2011/12 - 617 2012/13 - 708
Yellowknife (Fort Resolution and Lutsel K'e)	• Home management, personal care, nursing care, meal preparation, Elder's fitness program, cases assessment and coordination, in-home respite and palliative care.	109	2010/11 - 62 2011/12 - 62 2012/13 - 52

From 2010/11 to 2012/13, the total number of HCC clients increased for YHSSA (Yellowknife, Dettah and N'Dilo), BDHSSA and DHSSA; remained relatively unchanged for FSHSSA and TCSA; and decreased for YHSSA (Fort Resolution and Lutsel K'e), HRHSSA and SHSSA (Figure 4). Overall, the total number of HCC clients in the NWT increased slightly from 1,979 in 2010/11 to 2,071 in 2012/13.

Figure 4: Number of Clients by HSSA from 2010/11 to 2012/13[9]



The proportion of clients under the age of 65 and 65 and older varied by HSSA (Table 4).

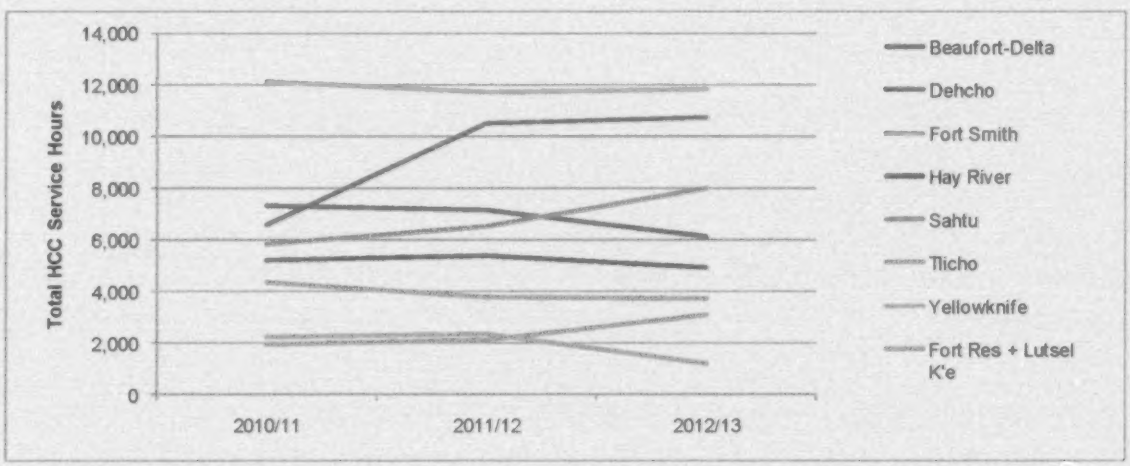
[9] Based on Total Health Suite data for each HSSA from 2010/11, 2011/12 and 2012/13.

Table 4: Age Distribution of HCC Clients by HSSA from 2010/11 to 2012/13

HSSA	2010/11		2011/12		2012/13	
	0 - 64	65 & Over	0 - 64	65 & Over	0 - 64	65 & Over
Beaufort-Delta	124	211	142	191	112	239
Dehcho	88	191	102	206	103	217
Fort Smith	34	85	25	80	34	87
Hay River	181	150	135	143	136	141
Sahtu	34	160	42	109	27	116
Tlicho	37	69	21	46	21	78
Yellowknife (Yellowknife, Dettah and N'Dilo)	342	211	391	226	464	244
Yellowknife (Fort Resolution and Lutsel K'e)	11	51	18	44	19	33
NWT Total	**851**	**1,128**	**876**	**1,045**	**916**	**1,155**

From 2010/11 to 2012/13, the total number of HCC service hours provided increased for the BDHSSA, SHSSA and TCSA and decreased for the other HSSAs (Figure 5).

Figure 5: Total HCC Service Hours by HSSA from 2010/11 to 2012/13[10]



Most of the HCC service hours in each HSSA were for the provision of care to chronic clients (Table 5). The number of service hours spent providing care to acute post-hospital clients was significant and

[10] Based on Based on Total Health Suite data for each HSSA from 2010/11, 2011/12 and 2012/13.

increased from 2010/11 to 2012/12 for the HRHSSA and YHSAA, but did not represent a major portion of service hours for the remaining HSSAs.

Table 5:Total Number of Hours of Service by Client Type for each HSSA[11]

HSSA	Acute Clients*	Acute Post-Hospital	Chronic Clients**	Disabled	Long Term	Palliative	Short Term/ Non Client***	Total
Beaufort-Delta								
2010/11	36	58	6,161	184	3	115	0	**6,556**
2011/12	81	74	9,982	215	2	156	0	**10,509**
2012/13	65	91	10,293	195	2	111	0	**10,757**
Dehcho								
2010/11	376	82	6,502	291	58	0	0	**7,309**
2011/12	503	32	6,430	30	80	60	0	**7,136**
2012/13	29	73	5,834	136	31	19	0	**6,121**
Fort Smith								
2010/11	0	147	4,190	0	0	0	0	**4,337**
2011/12	0	71	3,678	0	0	0	0	**3,749**
2012/13	0	116	3,543	0	0	57	0	**3,716**
Hay River								
2010/11	307	198	3,665	210	804	1	41	**5,227**
2011/12	350	507	3,441	158	850	20	71	**5,397**
2012/13	783	746	2,335	171	642	106	142	**4,925**
Sahtu								
2010/11	58	87	5,596	40	10	13	0	**5,803**
2011/12	11	21	6,409	50	1	26	0	**6,519**
2012/13	23	21	7,815	59	1	78	0	**7,997**
Tlicho								
2010/11	3	4	1,941	0	0	2	0	**1,949**
2011/12	25	0	2,064	0	0	0	0	**2,089**
2012/13	0	0	3,081	0	1	0	0	**3,082**

[11] Based on Based on Total Health Suite data for each HSSA from 2010/11, 2011/12 and 2012/13.

HSSA	Acute Clients*	Acute Post-Hospital	Chronic Clients**	Disabled	Long Term	Palliative	Short Term/ Non Client***	Total
Yellowknife (Yellowknife, Dettah and N'Dilo)								
2010/11	101	2,189	8,581	0	0	855	379	**12,103**
2011/12	7	3,028	8,321	2	0	233	118	**11,709**
2012/13	45	2,967	7,901	0	0	667	268	**11,847**
Yellowknife (Fort Resolution and Lutsel K'e)								
2010/11	3	0	2,229	0	0	5	0	**2,236**
2011/12	0	0	2,295	48	0	4	0	**2,347**
2012/13	0	0	1,089	37	0	54	0	**1,180**

* Includes acute chronic and acute mental health clients.
** Includes chronic continuous, chronic mental health and chronic time limited clients.
*** Represents short-term for Hay River and non-client for Yellowknife.

The provision of HCC activities varies by HSSA as shown by the variation in the breakdown of HCC service activity hours (Table 6). Home making and personal care activities represent a significant portion of HCC activity in some HSSAs (DHSSA, FSHSSA, SHSSA and TCSA) while nursing activities represent a significant portion of HCC activity in other HSSAs (HRHSSA and YHSSA).

Table 6:Total Number of Hours of Service by Activity for each HSSA[12]

HSSA	Total Home Making*	Personal Care	In-Home Respite	Case Assess Coord.	Nursing	Supportive Services	Total
Beaufort-Delta							
2010/11	2,483	1,676	1,410	375	612	0	**6,556**
2011/12	2,907	2,433	2,448	366	2,356	0	**10,509**
2012/13	2,549	2,315	2,522	498	2,873	0	**10,757**
Dehcho							
2010/11	3,558	1,281	1,903	563	3	0	**7,309**
2011/12	3,252	1,642	1,700	509	33	0	**7,136**
2012/13	2,499	1,510	1,626	477	9	0	**6,121**

[12] Based on Based on Total Health Suite data for each HSSA from 2010/11, 2011/12 and 2012/13.

HSSA	Total Home Making*	Personal Care	In-Home Respite	Case Assess Coord.	Nursing	Supportive Services	Total
Fort Smith							
2010/11	2,855	86	0	0	1,397	0	**4,337**
2011/12	2,300	168	0	0	1,282	0	**3,749**
2012/13	2,216	75	0	1	1,424	0	**3,716**
Hay River							
2010/11	891	1,031	268	126	2,872	39	**5,227**
2011/12	865	847	223	364	3,079	18	**5,397**
2012/13	813	632	384	345	2,691	60	**4,925**
Sahtu							
2010/11	2,193	1,227	1,074	1,004	306	0	**5,803**
2011/12	2,753	1,093	1,608	858	207	0	**6,519**
2012/13	3,419	1,499	1,565	1,059	456	0	**7,997**
Tlicho							
2010/11	792	574	364	116	103	0	**1,949**
2011/12	827	679	521	61	1	0	**2,089**
2012/13	935	1,500	616	31	0	0	**3,082**
Yellowknife (Yellowknife, Dettah and N'Dilo)							
2010/11	2,130	1,845	725	2,076	4,876	451	**12,103**
2011/12	2,184	1,413	974	1,413	5,075	650	**11,709**
2012/13	2,310	957	443	1,760	5,347	1,030	**11,847**
Yellowknife (Fort Resolution and Lutsel K'e)							
2010/11	1,763	63	37	145	229	0	**2,236**
2011/12	1,711	61	16	148	410	0	**2,347**
2012/13	690	90	3	46	351	0	**1,180**

* Includes home management and meal preparation.

The total HCC staffing levels in each HSSA has remained relatively consistent from 2011/12 to 2013/14 except for the HRHSSA which had a reduction of 1 full-time equivalent (FTE) in 2012/13 (Table 7). However, the mix of HCC staff used to deliver services varies by HSSA (Table 7).

Table 7: Staffing Levels and Service Provider Mix by HSSA[13]

HSSA	2011/12			2012/13			2013/14		
	Core	FNIHCC*	Total	Core	FNIHCC	Total	Core	FNIHCC	Total
Beaufort-Delta									
HSW	9.0	5.0	14.0	9.0	6.0	15.0	9.0	6.0	15.0
Nursing	-	0.5	0.5	-	0.5	0.5	-	0.5	0.5
HCC Coordinator	-	1.0	1.0	-	1.0	1.0	-	1.0	1.0
Other[14]	-	3.0	3.0	-	2.0	2.0	-	2.0	2.0
Total	**9.0**	**9.5**	**18.5**	**9.0**	**9.5**	**18.5**	**9.0**	**9.5**	**18.5**
Dehcho									
HSW	4.5	3.0	7.5	4.5	3.0	7.5	4.5	3.0	7.5
Nursing	-	-	-	-	-	-	-	-	-
Regional Coordinator	-	1.0	1.0	-	1.0	1.0	-	1.0	1.0
Other[15]	0.5	0.5	1.0	0.5	0.5	1.0	0.5	0.5	1.0
Total	**5.0**	**4.5**	**9.5**	**5.0**	**4.5**	**9.5**	**5.0**	**4.5**	**9.5**
Fort Smith									
HSW	2.0	1.5	3.5	2.0	1.5	3.5	2.0	1.5	3.5
Nursing	2.0	1.0	3.0	2.0	1.0	3.0	2.0	1.0	3.0
HCC Coordinator	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-
Total	**4.0**	**2.5**	**6.5**	**4.0**	**2.5**	**6.5**	**4.0**	**2.5**	**6.5**
Hay River									
HSW	2.5	-	2.5	2.5	-	2.5	2.5	-	2.5
Nursing	4.0	1.0	5.0	3.0	1.0	4.0	4.0	1.0	5.0
HCC Coordinator	-	-	-	-	-	-	-	-	-
Other[16]	-	1.0	1.0	-	1.0	1.0	-	1.0	1.0
Total	**6.5**	**2.0**	**8.5**	**5.5**	**2.0**	**7.5**	**6.5**	**2.0**	**8.5**
Sahtu									
HSW	5.5	2.0	7.5	5.0	2.5	7.5	5.0	2.5	7.5
Nursing	-	1.0	1.0	-	1.0	1.0	-	1.0	1.0
HCC Coordinator	-	-	-	-	-	-	1.0	-	1.0
Other	-	-	-	-	-	-	-	-	-
Total	**5.5**	**3.0**	**8.5**	**5.0**	**3.5**	**8.5**	**6.0**	**3.5**	**9.5**

[13] Based on the HCC staffing levels provided by the Department.
[14] Includes Meal Prep (2011/12 only), Clerical Support and Medical Social Work positions.
[15] Includes Activity Aide position.
[16] Includes Dietician position.

HSSA	2011/12			2012/13			2013/14		
	Core	FNIHCC*	Total	Core	FNIHCC	Total	Core	FNIHCC	Total
Tlicho									
HSW	4.0	0.5	4.5	4.0	0.5	4.5	4.0	0.5	4.5
Nursing	1.5	2.0	3.5	1.5	2.0	3.5	1.5	2.0	3.5
HCC Coordinator[17]	2.0	-	2.0	2.0	-	2.0	2.0	-	2.0
Other[18]	-	2.5	2.5	-	2.5	2.5	-	2.5	2.5
Total	**7.5**	**5.0**	**12.5**	**7.5**	**5.0**	**12.5**	**7.5**	**5.0**	**12.5**
Yellowknife (Yellowknife, Dettah and N'Dilo)									
HSW	5.5	2.0	7.5	5.5	2.0	7.5	5.5	2.0	7.5
Nursing	8.0	2.0	10.0	8.0	2.0	10.0	8.0	2.0	10.0
HCC Coordinator[19]	3.0	-	3.0	3.0	-	3.0	3.0	-	3.0
Other[20]	-	3.0	3.0	-	3.0	3.0	-	3.0	3.0
Total	**16.5**	**7.0**	**23.5**	**16.5**	**7.0**	**23.5**	**16.5**	**7.0**	**23.5**
Yellowknife (Fort Resolution and Lutsel K'e)									
HSW[21]	2.0	1.6	3.6	2.0	1.6	3.6	2.0	1.6	3.6
Nursing	-	-	-	-	-	-	-	-	-
HCC Coordinator	-	-	-	-	-	-	-	-	-
Other[22]	1.0	0.2	1.2	1.0	0.2	1.2	1.0	0.2	1.2
Total	**3.0**	**1.8**	**4.8**	**3.0**	**1.8**	**4.8**	**3.0**	**1.8**	**4.8**

* Represents positions funded from FNIHCC funding from the First Nations and Inuit Health Branch (FNIHB).

3.1.2 Home and Community Care Funding

The HCC services provided in the NWT are funded through Department core funding as well as from the First Nation and Inuit Home and Community Care Program (FNIHCC), which is administered by the Department on behalf of the First Nations and Inuit Health Branch (FNIHB). The Department currently has a 5 year agreement with FNIHB for the FNIHCC funding that expires March 31, 2018 and allocates the funding to each HSSA through a separate contribution agreement. . The core HCC funding is administered by the Department as part of the Core Funding Contribution Agreements with each HSSA.

[17] Includes Manager of Continuing Care position.
[18] Includes Medical Social Worker, Recreational Activity Coordinator and Interpreter positions.
[19] Includes HSW Supervisor, Referral Care Coordinator and Manager positions.
[20] Includes Unit Clerk, Dietician and Medical Social Worker positions.
[21] Includes Home Maker position.
[22] Includes Elders Lunch Cook and Program Fitness Coordinator positions.

The core HCC funding provided by the Department is allocated based on historical funding levels with a provision for inflation. The funding provided to each HSSA is not allocated based on any type of formula that accounts for demographics or service requirements.

The FNIHCC funding is allocated based on proposal submissions from each HSSA. Based on an analysis of the FNIHCC contribution agreements for the different HSSAs, the requirements for securing FNIHCC funding do not appear to be consistent. The content describing the background and project being funded for each HSSA in the contribution agreements is not provided in a consistent format. In some FNIHCC contribution agreements, it is unclear as to what the HSSAs are being funded to accomplish with the FNIHCC funding, which would make the assessment of outcomes difficult for the Department.

There are no requirements to report on HCC activity and outcomes for the core HCC funding provided through the Core Funding Contribution Agreements. However, the FNIHCC Contribution Agreements do require that HSSAs report on the results and success of the project they were funded for. Some Department representatives expressed concern that there were no reporting requirements for the core HCC funding which made it difficult to assess whether these funds were being spent appropriately on HCC services.

Table 8 below provides a summary of the level of HCC funding for the 2012/13 fiscal year and funding and spending for the 2011/12 and 2010/11 fiscal years. In 2012/13, there was a total budget of approximately $9.8 million, of which approximately $6.1 million (62%) was core HCC funding and $3.7 million (38%) was FNIHCC funding. However, some of the additional FNIHCC funding in 2012/13 was due to carry over from the previous year. The total budget for 2012/2013 was 8.8% higher than the total budget of approximately $9 million for 2011/2012 and 25% higher than the total budget of approximately $7.9 million for 2010/11. The budget for 2013/14 is $9.7 million.

The budget of $9 million in 2011/12 included $6.3 million (70%) of core HCC funding and $2.7 million (30%) of FNIHCC funding. The budget of $7.9 million in 2010/11 included 5.25 million (66%) of core HCC funding and $2.65 million (34%) of FNIHCC funding.

Overall, total spending was approximately $9.1 million in 2011/12 resulting in a total deficit of $65,300. The deficit for the 2010/11 fiscal year was $428,390. The observed deficits were driven primarily by overspending in FNIHCC funding for the BDHSSA which was due to no FNIHCC budget value being provided in 2010/11 and 2011/12 (Table 8).[23]

A representative from the Department indicated that there was no overspending for FNIHCC funding in 2010/11 and 2011/12 and that there has been budget carryovers due to surpluses. It was noted that these carryovers have not been captured in the financial numbers provided by the Department and it was unclear as to why this had occurred.

[23] Based on the Homecare Budget numbers for 2004/05 to 2012/13 provided by the Department.

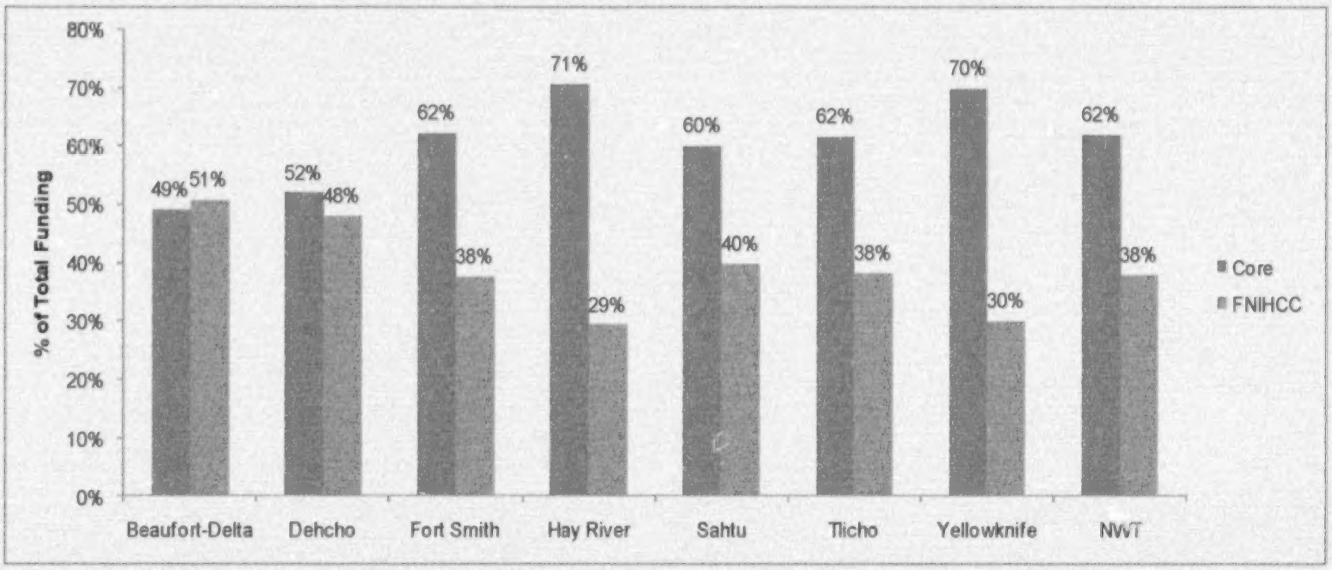
Table 8: HCC Funding and Spending[24]

HSSA	2012/13 Budget ($)	2011/12 Budget ($)	2011/12 Actual ($)	2011/12 Variance ($)	2010/11 Budget ($)	2010/11 Actual ($)	2010/11 Variance ($)
Beaufort-Delta Total	**1,867,163**	**1,404,328**	**1,539,368**	**(135,040)**	**764,821**	**1,459,551**	**(694,730)**
Core	918,643	1,404,328	562,392	841,936	764,821	697,151	67,670
FNIHCC	948,520	-	976,976	(976,976)	-	762,400	(762,400)
Dehcho Total	**991,733**	**948,92**	**1,008,654**	**(59,728)**	**784,124**	**817,692**	**(33,568)**
Core	515,237	472,430	532,158	(59,728)	384,124	447,250	(63,126)
FNIHCC	476,496	476,496	476,496	-	400,000	370,442	29,558
Fort Smith Total	**578,000**	**564,823**	**550,242**	**14,581**	**620,266**	**548,656**	**71,610**
Core	360,000	346,823	328,587	18,236	398,000	324,234	73,766
FNIHCC	218,000	218,000	221,655	(3,655)	222,266	224,422	(2,156)
Hay River Total	**986,471**	**1,003,030**	**983,218**	**19,812**	**876,946**	**886,793**	**(9,847)**
Core	697,063	705,000	693,810	11,190	548,000	577,762	(29,762)
FNIHCC	289,408	298,030	289,408	8,622	328,546	309,031	19,515
Sahtu Total	**905,167**	**848,637**	**980,635**	**(131,998)**	**830,592**	**838,861**	**(8,269)**
Core	544,303	414,447	585,416	(170,969)	424,178	439,035	(14,857)
FNIHCC	360,864	434,190	395,219	38,971	406,414	399,826	6,588
Tlicho Total	**1,032,900**	**1,002,678**	**1,059,374**	**(56,696)**	**902,607**	**852,953**	**49,654**
Core	637,275	607,053	651,856	(44,803)	485,610	464,408	21,202
FNIHCC	395,625	395,625	407,518	(11,893)	416,997	388,545	28,452
Yellowknife Total	**3,487,720**	**3,277,216**	**2,993,448**	**283,768**	**3,115,002**	**2,918,242**	**196,760**
Core	2,437,112	2,346,321	2,062,552	283,769	2,244,155	2,074,841	169,314
FNIHCC	1,050,608	930,895	930,896	(1)	870,847	843,401	27,446
NWT Total	**9,849,154**	**9,049,639**	**9,114,939**	**(65,300)**	**7,894,358**	**8,322,748**	**(428,390)**
Core	6,109,633	6,296,403	5,416,771	879,632	5,249,288	5,024,681	224,607
FNIHCC	3,739,521	2,753,236	3,698,168	(944,932)	2,645,070	3,298,067	(652,997)

The breakdown of core HCC and FNIHCC funding for each HSSA for the 2012/13 fiscal year is shown below (Figure 6). The BDHSSA had the highest proportion of FNIHCC funding at 51% in 2012/13 and HRHSSA had the lowest proportion at 29%.

[24] Based on the Homecare Budget numbers for 2004/05 to 2012/13 provided by the Department.

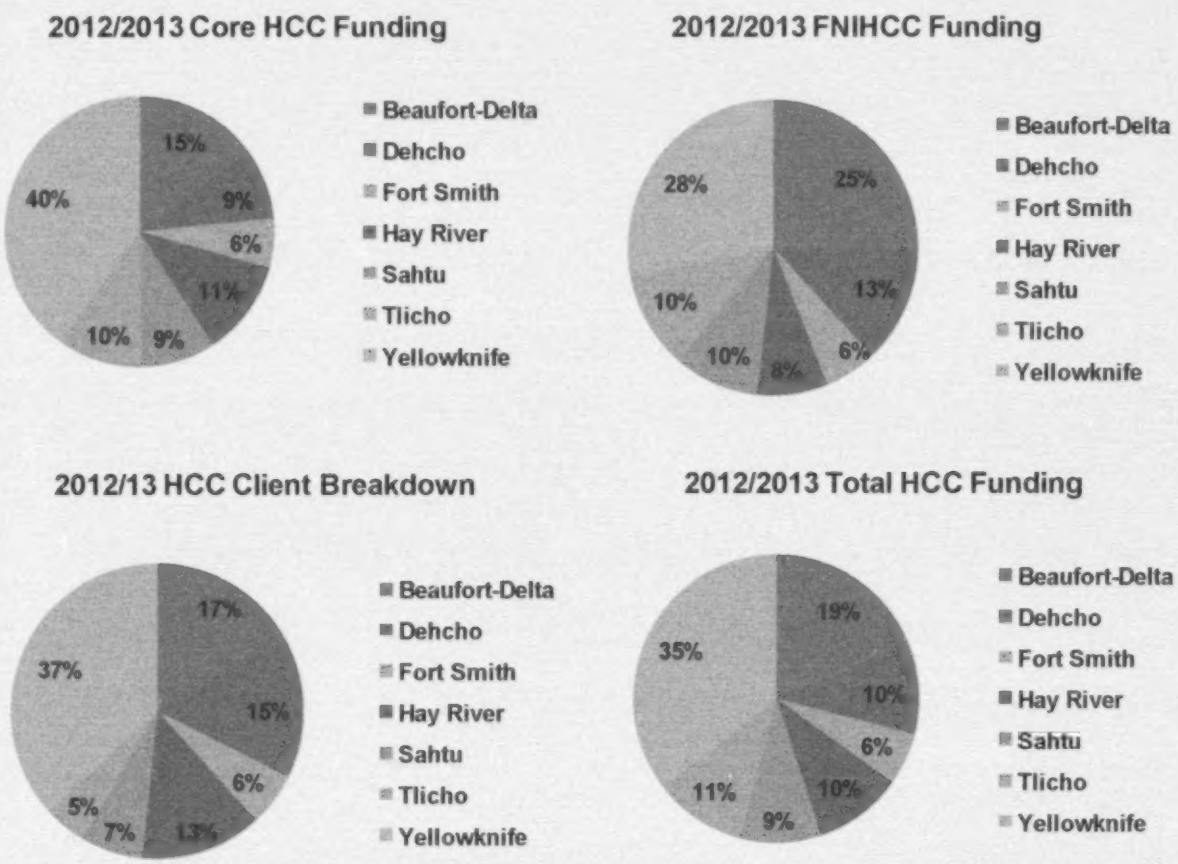
Figure 6: Breakdown of 2012/13 Home and Community Care Funding by HSSA[25]



The YHSSA received $3.5 million or 35% of the total HCC funding available in the NWT in 2012/13 and served 37% of the HCC clients in the NWT (Figure 7). The other six HSSA received the remaining 65% of funding and served 63% of the remaining HCC clients (Figure 7). The YHSSA also received 40% of the total core HCC available and 28% of the total FNIHCC funding available. The BDHSSA received 19% of the total funding available and 25% of the FNIHCC funding available, but only served 17% of HCC clients.

[25] Based on data provided by Department.

Figure 7: Breakdown of 2012/13 Home and Community Care Funding by HSSA[26]



[26] Based on data provided by the Department.

3.1.3 Program collaboration with NWT Housing Corporation

Public housing provided by the NWT Housing Corporation (NWTHC) plays an important role in providing affordable housing in many NWT communities. It is estimated that there are approximately 634 Elders 60 years and older that reside in public housing in the NWT.[27] There are currently 339 independent housing units in the NWT targeted for Elders and persons with disabilities. A breakdown of the targeted independent housing units by HSSA is provided in Table 9.

Table 9: Inventory of Independent Housing Units Targeted for Elders and Persons with Disabilities[28]

HSSA	Independent Housing Units
Beaufort-Delta	70
Dehcho	50
Fort Smith	43
Hay River	86
Sahtu	16
Tlicho	14
Yellowknife	60
Total	**339**

The NWTHC has developed a plan to build, replace, and renovate independent housing units for seniors in a number of NWT communities. The Department is working closely with NWTHC to ensure HCC supports can be provided to seniors living in independent housing through design that allows space for program delivery. The NWTHC is currently planning the development of four independent living facilities for Elders within the communities of Fort McPherson, Fort Good Hope, Fort Liard and Whati. This will result in 32 additional independent living units which are specifically targeted at Elders and will provide them with an opportunity to live in their communities longer. Each facility will contain eight independent housing units, one caretaker unit as well as space for the delivery of home care services, common spaces for gathering and programming, laundry, kitchen, tub room/bathrooms, and security.[29]

3.1.4 Key Informant Perceptions of Home and Community Care Services

A summary of notable perceptions about HCC services are provided in the bulleted points below.

- Some key informants noted concern over the strong reliance of HCC in the NWT on FNIHCC funding. Since this funding is provided by FNIHB and not in the control of the Department, there is a risk that this funding could be lost at some point which could have significant negative impacts to service delivery. It was noted that the FNIHCC funding is more consistent now than it has been in the past.

[27] NWT Continuum of Care Evaluation Request for Proposals. PM014816.
[28] Data provided by the Department.
[29] Based on NWTHC focus group and http://news.exec.gov.nt.ca/supported-housing-for-seniors/ (Accessed August 2, 2013).

- The delivery of HCC services across the NWT was perceived to be fragmented and inconsistent and dependent upon the capacity of the HSSA and competency of the workers in each community. There are currently no consistent standards for service delivery across the territory. The 2002 Standards for Home and Community Care and Long Term Care do not provide sufficient direction to the HSSAs. It was felt by some key informants that there is a need to develop a territorial vision for HCC to identify what services to focus on. The Department is working to finalize draft Continuing Care Standards that includes HCC program standards.

- Disparities and inequities between HSSAs were noted by some and thought to be due to the historical funding approach for HCC services. For example:
    - Most key informants consulted believed the number of HCC nurses in Yellowknife was too low.
    - Some believed Yellowknife had a much smaller ratio of nurses to population compared to other smaller communities in the territory.

- There are inconsistencies in the way that some HSSAs pay HCC nurses. HCC budgets are developed based on level 4 funded positions; however there are some HSSAs are hiring HCC nurses at a level 6 which could result in funding deficits.

- There is no consistent approach for admission into the HCC program within the different HSSAs.
    - Many key informants reported that admission into HCC was based on demand (those who ask for services) rather than based on need (assessment).
    - A proper assessment tool was required to assess clients based on need. The Inter-RAI Home Care tool was identified by many as an improved assessment tool for HCC admissions that could also provide the Department with better data collection. The tool could be used for admissions into HCC as well as admissions into LTC allowing for improved information sharing and data collection across Continuing Care programs. Inter-RAI is used in many Canadian jurisdictions and is the standard tool used for HCC service decisions.
    - The YHSSA indicated that they use a priority screening tool and single point of entry and admission coordinator for admission into home care. Some key informants felt that the approach of having a single point of entry assessment could work for other HSSAs.

- The retention of staff is a challenge for communities located outside of Yellowknife. The transient staffing creates challenges for consistent assessment, oversight, and service delivery.

- There has been an increase in the acuity of clients receiving HCC due to discharges from acute care facilities in the NWT as well as other jurisdictions such as Alberta. These clients have more complex requirements for wound care and staff require training to ensure they have the competencies to handle these more complex treatments.
    - The increase in client acuity is also being driven by a desire of Elders to remain in the home longer, resulting in the need to care for more complex conditions in the home.
    - The need for more complex care and higher acuity clients is expected to increase in the future and will create a need for more expert resources which are not available in each jurisdiction. Needs were identified for geriatrics, geriatric psychiatry, dietician services and rehabilitation services. One suggested approach to address this issue was to develop a pool of expert resources that travel to different communities to provide support and services.

- The need to improve communication between HCC and primary care/acute care was also identified. There have been challenges associated with the communication of discharges

between facilities and HCC staff. Some of this is due to the challenges with hiring and retaining regional home care coordinators because they are paid less than CHNs.

- A need for a restorative approach to Continuing Care including HCC services was identified. A restorative approach is focused on assisting individuals to improve their level of independence to return home or to their safest living environment following a serious injury or illness. It is for individuals who are medically stable and no longer require hospital level care but may not yet be ready to safely return home. Restorative approaches to care are being implemented in other jurisdictions.

- Concerns were expressed regarding the appropriate utilization of HSWs in the community.
    - There are some HSWs providing services such as hauling water and wood cutting to community members that were perceived to be not appropriate. HSWs have a hard time declining requests to complete these tasks.
    - Some believed that HSWs spend more time than they should providing transportation services to HCC clients which decreased the amount of time available to provide home making and personal care support.
    - Having a clearly defined scope of services, service limits, and a proper assessment tool were suggested as a way to improve this.

- A number of HSSAs noted that there is a need for more resources in order to expand services and hours of operation of HCC. Some HSSAs indicated that they already provide extended hours for evening tuck-in services as well as weekend services.

- Inconsistencies between and within HSSAs with the management and coordination of HCC staff was noted.
    - In some HSSAs, there are HCC coordinators who provide supervision, while in others oversight is provided by the Nurse in Charge or a Community Health Nurse of the local health centre, which creates challenges because HCC is not necessarily a priority for these nurses.
    - Some HSSAs have had high turnover at the HCC Coordinator position which leads to service decline.
    - Some key informants have suggested using a regional nurse to act as a coordinator in situations where there is no local HCC coordinator available.
    - There is a need for nursing supervision of HSWs and good communication between HSWs and nurses.

- A need for better data collection for all areas of continuing care was identified including HCC.
    - Currently, data is not captured in a timely manner for decision making. Data is currently entered into Health Suite and is dependent on the entry of data by staff in each HSSA.
    - Health Suite is not seen as a good tool for reviewing data by community.
    - The use of Inter-RAI could improve data collection for assessments and provide accountability for reporting to funders, but would not necessarily positively improve charting. It was thought by some that the use of electronic pens could improve data collection from a charting perspective.
    - It was identified that there is a need for HCC supports to assist Elders and individuals with disabilities to remain in their community. Further collaboration between the Department and NWTHC is important for developing appropriate infrastructure and services.

3.1.5 Respite Services

Respite care compliments Continuing Care service delivery and the ability to allow residents to age in their communities longer. It is a service that supports families by providing temporary care to an elder, adult or child with a disability in their own home or in a respite bed in a facility so that the caregiver(s) have a break.

Information on changing demographics and trends in health care confirm the importance of implementing a respite service (rather than program) that is part of a network of services to support the caregiver and the care recipient. Factors such as growth in the elder's population, increase in number of elders with some degree of dementia, increase in number of children with fetal alcohol syndrome (FASD) or other developmental delays, increase in number of children with special needs being cared for in homes and small communities, need for home care and home support expansion into small communities to support family caregivers, and changing hospital approaches to outpatient procedures and early discharge support the growing need for a Territory-wide approach to respite services.

3.1.5.1 Inventory of Respite Services

Current respite services in the NWT include:

- Respite offered through the HCC program;
- Respite beds in long-term care facilities and the Hay River Supported Living Campus; and
- Social and/or community-based respite services delivered by non-government organizations (NGOs) or through voluntary service agreements with HSSAs.

Currently, the costs associated with in-facility respite care including travel and accommodation (if required) as well as facility costs/fees are not covered by the NWT. This means that these costs must be covered by the family and/or client which has limited the access to respite care.

The provision of respite services in the community and/or in the home currently varied by HSSA based on the level of funding and staffing available. This is evident by the number HCC hours of service spent providing in-home respite care (Table 6 above). Some HSSAs such as BDHSSA, DHSSA, SHSSA and TCSA spent more hours on the provision of respite care than other HSSAs.

The provision of in-community respite care for some HSSAs is provided by NGOs including:

- Yellowknife Association of Community Living (YACL) for Yellowknife, Dettah and N'Dilo, and
- NWT Disabilities Council (NWTDC) – Aklavik, Fort Smith and Deline.

There are currently 14 beds designated for in-facility respite services in the NWT including 12 in LTC facilities, and 2 in a supported living facility (Table 10). There are also 2 beds at H.H. Williams in Hay River which are sometimes used for respite care, but not designated for this purpose. There will be 2 beds included in the new LTC facility in Behchoko (replaces bed at Jimmy Erasmus) and 2 beds in the new Norman Wells LTC facility that can be used for respite care or palliative care. This would bring the total respite bed count to 18 beds in the NWT.

Table 10: Inventory of Respite Beds in NWT[30]

Facility	Location	HSSA	Respite Beds
Aven Cottages	Yellowknife	Yellowknife	4
Stanton Extended Care Unit	Yellowknife	Stanton	1
Jimmy Erasmus Senior's Home	Behchoko	Tlicho	1
Northern Lights Special Care Home	Fort Smith	Fort Smith	2
Fort Simpson Long Term Care	Fort Simpson	Dehcho	1
Inuvik Regional Long Term Care	Inuvik	Beaufort-Delta	3
Hay River Supported Living Campus	Hay River	Hay River	2
Total			**14**

3.1.5.2 Adult Day Services

Adult day services offer a range of activities in a safe social environment to individuals who live at home as independently as possible. This service also provides respite for family caregivers by providing a break from their care giving. Adult day activities may vary by program, but included:

- Therapeutic recreation activities
- Assistance with personal hygiene
- Social activities such as discussion groups, entertainment and crafts as well as noon meals
- Health monitoring and personal care assistance

Currently, adult day services are offered by both HCC and LTC programs and are available in some communities including:

- Avens – Adult Day Program,
- Inuvik Regional Hospital – Elders Day Program
- Behchoko – Elders Day Program
- Aklavik- Elders Day Program

Adult day services are integrated into the Department's LTC prototype, so as new LTC facilities are built in Behchoko and Norman Wells, space and resources will be put in place for this programming. Additionally, as the Department continues to work with the NWTHC to design new independent housing facilities, resources will be required to add programming within these facilities.

3.1.5.3 Key Informant Perceptions of Respite Care Service Delivery

A summary of notable perceptions about Respite Care Services are provided in the bulleted points below.

- Key informants believe that the needs for respite services were not being met in the NWT. Also, the degree to which respite services were available in each HSSA varied as there were respite beds available in some HSSAs but not in others. Some HSSAs noted that they are providing the best care that they can, but they lack the resources and ability to meet the expectations of residents. One individual noted that a survey was conducted for those who received respite care and found that they don't feel that they are getting the best quality respite care.

[30] Evaluation of NWT Respite Services. DPRA. May 2013.

- Some key informants noted that respite care was costly for families who did not live in close proximity to a facility with a respite bed. Respite care services are not covered by insurance meaning that families must cover the costs for travel, accommodation and fees for in-facility respite care. This makes respite services cost prohibitive for many.

- Some key informants from Hay River felt that respite beds should not be located in the Hay River Health Centre. They felt that the respite beds should be located in a LTC setting. Some key informants felt that there should be more LTC beds designated for respite care. Representatives from the SHSSA felt that that the Department should consider designating more beds in the new LTC facility in Norman Wells for respite care (up to 6 beds) as the demand for respite services will increase given the desire for residents to remain in their home as long as possible.

- Some key informants noted that they keep patients who come in for respite care in respite beds who are awaiting placement into LTC until a LTC bed is available. In some instances, respite beds are also used for acute care purposes or alternate level of care patients awaiting placement at the Hay River Health Centre. Although this practice helps some patients transition to LTC, it was perceived by others to be risky as it ties up beds that could be used by others who need them.

- Some key informants believed that community-based respite services would be better serviced by the HSSAs than NGOs. This was due to:
    - The services being provided by local resources with local training; and
    - More standardized assessments.

3.1.5.4 NWT Respite Services Evaluation Findings

The Department recently had an evaluation completed of respite services in the NWT. The key findings from the evaluation included:[31]

- Respite care remains an important service offered throughout the NWT. No other service was identified as duplicating or overlapping the provision of respite care, highlighting its unique place in the continuum of health care services.
- There was general consensus that current respite services are not sufficiently reaching those in need due to:
    - An insufficient number of respite beds or misappropriation of respite beds by non-respite patients.
    - In-facility respite care may not meet the needs of all clients and care is not available in all communities.
    - Day programming is not available in all communities nor is it available to all types of respite clients.
    - After hour in-community respite care (evenings and weekends) is not readily available.
- There is considerable variability in the delivery of respite services and the staffing available to support it across the Territory and the eligibility criteria for respite clients varies by Continuing Care service area, NGO and HSSA.
- There was general consensus that respite care, when it is available and accessible, is beneficial to both the client and the family caregiver.
- The utilization rates for respite services were difficult to determine due to the fact that not all service providers collect information specific to respite patients and family caregivers and the

[31] Evaluation of NWT Respite Services. DPRA. May 2013

quality of data and reporting, in many instances, is quite poor. Based on the data available, the utilization of respite beds and services varied across the NWT. The occupancy rates of respite beds in some facilities were high while at other facilities they were not.

- There is a lack of Territory-wide standards for assessing respite patient and caregiver needs.

Information obtained from research on respite care, case studies on respite services offered in jurisdictions within Canada, regional focus groups held by the Department and the evaluation of respite services in the NWT highlighted the need for the implementation of a new model of respite care. A Territorial Flexible Respite Model Draft Business Case was prepared to present evidence in support of this model of care.

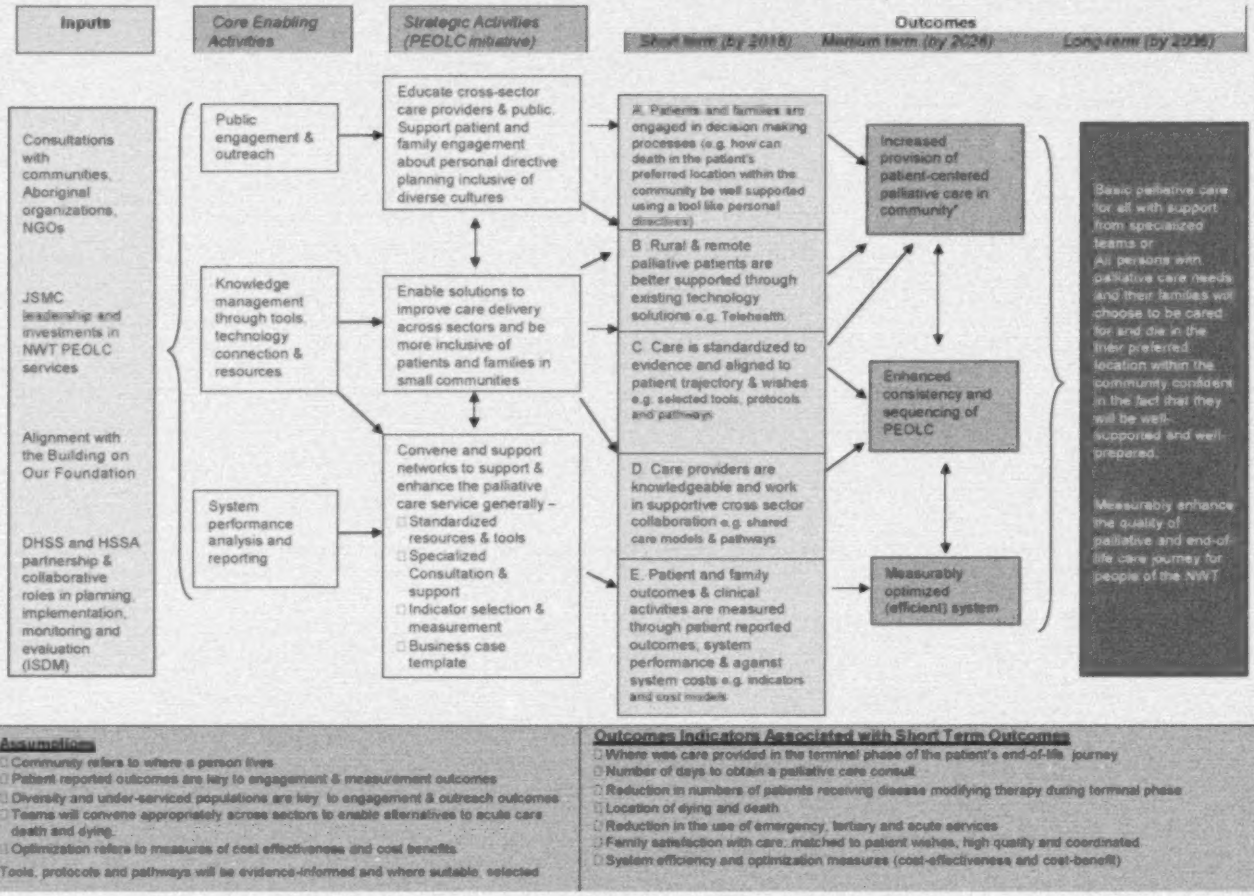
The business case outlines the roles, responsibilities and reporting; staffing requirements; financial overview; and potential benefits and risks of the new model. The business case focuses specifically on the provision of in-community and/or in-home respite services.

3.1.6 Palliative Care

In the NWT, palliative care services are provided in various locations including the client's home, in LTC facilities, and in acute care facilities. Like respite care, palliative care compliments the delivery of Continuing Care services. Figure 8 shows the adapted logic model for palliative care in the NWT that was recently developed by the Department based on the national Palliative and End of Life Care Initiative's Palliative Care Logic Model.

Most LTC facilities provide palliative care when requested. However, some HSSA representatives noted that they do not have a private space where families can go for privacy. There are also 2 beds planned for the purpose of palliative care or respite care in each of the new LTC facilities planned in Norman Wells and Behchoko. The HSSAs also provide palliative care in the home in collaboration with the family.

Figure 8: NWT Palliative Care Logic Model[32]


Inputs
Core Enabling Activities
Strategic Activities (PEOLC initiative)
Outcomes
Short term (by 2018)
Medium term (by 2024)
Long term (by 2024)
Consultations with communities, Aboriginal organizations, NGOs
JSMC leadership and investments in NWT PEOLC services
Alignment with the Building on Our Foundation
DHSS and HSSA partnership & collaborative roles in planning, implementation, monitoring and evaluation (ISDM)
Public engagement & outreach
Knowledge management through tools, technology connection & resources
System performance analysis and reporting
Educate cross-sector care providers & public. Support patient and family engagement about personal directive planning inclusive of diverse cultures
Enable solutions to improve care delivery across sectors and be more inclusive of patients and families in small communities
Convene and support networks to support & enhance the palliative care service generally –
Standardized resources & tools
Specialized Consultation & support
Indicator selection & measurement
Business case template
A. Patients and families are engaged in decision making processes (e.g. how can death in the patient's preferred location within the community be well supported using a tool like personal directives)
B. Rural & remote palliative patients are better supported through existing technology solutions e.g. Telehealth
C. Care is standardized to evidence and aligned to patient trajectory & wishes e.g. selected tools, protocols and pathways
D. Care providers are knowledgeable and work in supportive cross sector collaboration e.g. shared care models & pathways
E. Patient and family outcomes & clinical activities are measured through patient reported outcomes, system performance & against system costs e.g. indicators and cost models
Increased provision of patient-centered palliative care in community*
Enhanced consistency and sequencing of PEOLC
Measurably optimized (efficient) system
Basic palliative care for all with support from specialized teams or
All persons with palliative care needs and their families will choose to be cared for and die in the their preferred location within the community confident in the fact that they will be well-supported and well-prepared.
Measurably enhance the quality of palliative and end-of-life care journey for people of the NWT
Assumptions
Community refers to where a person lives
Patient reported outcomes are key to engagement & measurement outcomes
Diversity and under-serviced populations are key to engagement & outreach outcomes
Teams will convene appropriately across sectors to enable alternatives to acute care death and dying.
Optimization refers to measures of cost effectiveness and cost benefits
Tools, protocols and pathways will be evidence-informed and where suitable, selected
Outcomes Indicators Associated with Short Term Outcomes
Where was care provided in the terminal phase of the patient's end-of-life journey
Number of days to obtain a palliative care consult
Reduction in numbers of patients receiving disease modifying therapy during terminal phase
Location of dying and death
Reduction in the use of emergency, tertiary and acute services
Family satisfaction with care, matched to patient wishes, high quality and coordinated
System efficiency and optimization measures (cost-effectiveness and cost-benefit)

3.1.6.1 Key Informant Perceptions of Palliative Care Service Delivery

A summary of notable perceptions about Palliative Care Services are provided in the bulleted points below.

- The delivery of palliative care services across the NWT varies based on the resources available to provide the services.
    - Some HSSAs have developed policies and guidelines or manuals for palliative care and others have not. For example, the YHSSA has developed guidelines and the HRHSSA has developed a manual based on the Victoria Hospice.
    - Many key informants noted a need for consistent standards and clinical practice guidelines for palliative care in the NWT.
- It was noted that there is a growing interest by residents in the NWT to receive palliative care services.

[32] Provided by the Department.

- The delivery of palliative care services was perceived to be improving, especially the delivery of in-home palliative care services in communities outside of Yellowknife.
    - The needs for palliative care were perceived as being met in some HSSAs, while other HSSAs felt that they were doing the best they can on an ad-hoc basis.
    - One HSSA representative noted that providing proper pain management was an issue.
- The HSSAs were perceived as being committed and going out of their way to provide palliative care in the communities. Staff provide palliative care to patients outside of normal work hours while still doing their regular jobs sometimes resulting in overtime.
    - This dedication was noted by some to be straining the system in these communities and there were some concerns for staff burnout.
- Many key informants indicated the need to have nurses, staff and families trained to understand palliative care and their role in providing palliative care. This was considered important given that in-home palliative care is provided in many communities. Some HSSAs employ nurses who have experience with palliative care while other HSSAs have provided training to their staff.

3.2 Long-Term Care

The following section describes the current state of LTC programs and services in the NWT including the number of LTC beds by facility in the territory, utilization statistics, an assessment of the Territorial Admissions Committee (TAC) function and processes, LTC facility staffing, LTC funding, and perceptions of LTC funding.

3.2.1 NWT Long-Term Care Bed Numbers

The current stock of LTC beds in the NWT is represented below (Table 11). There are currently 173 LTC beds in the NWT including 160 full time beds, 12 respite beds and one palliative bed located in nine distinct facilities. Three of the facilities are located in Yellowknife, and two are located in Hay River, with the remaining four facilities being located in Behchoko, Fort Simpson, Fort Smith and Inuvik. All but two of the LTC facilities (Fort Simpson LTC facility and the Jimmy Erasmus Senior's Home) are accredited. Some key informants noted a desire to have all facilities in the NWT accredited.

Table 11: Current Stock of LTC Beds in the NWT[33]

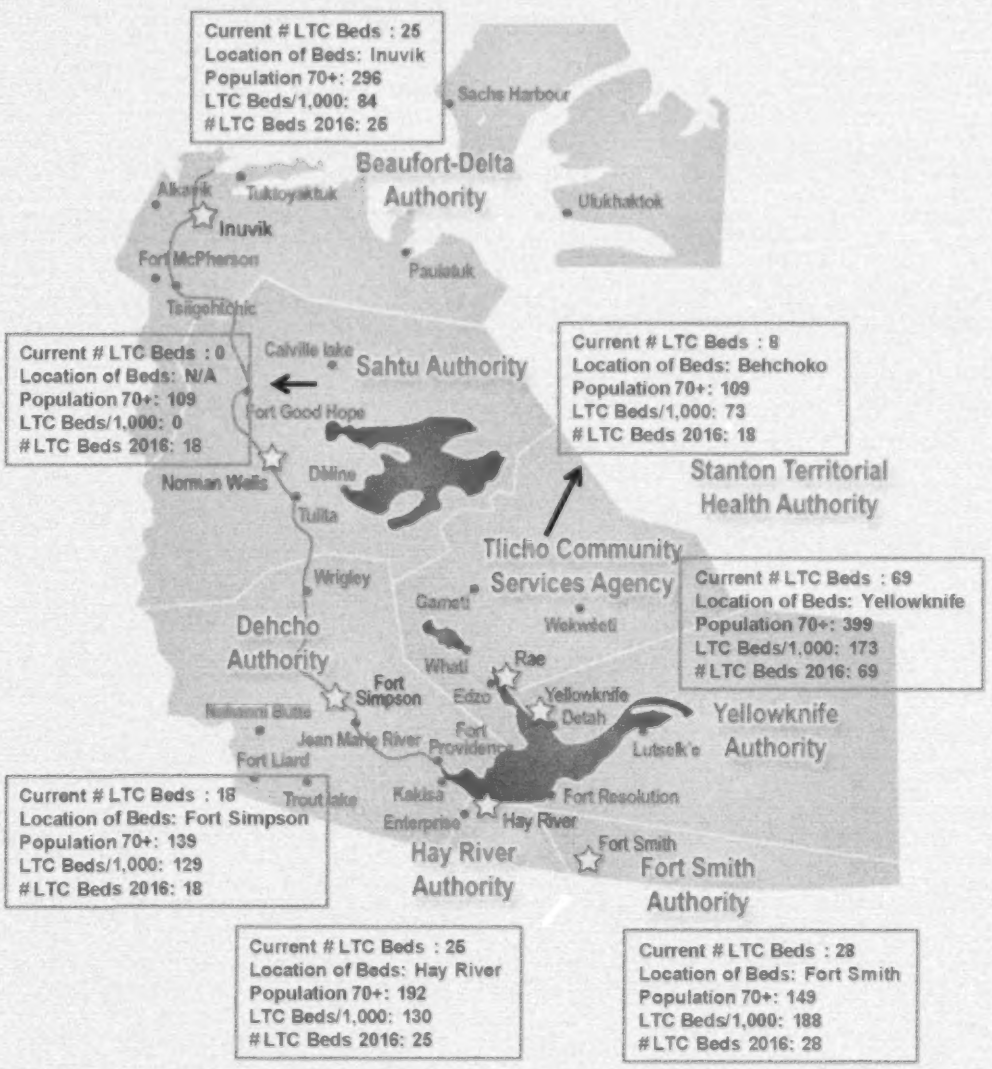
Facility	Location	HSSA	Full-Time LTC Beds	Respite/ Palliative Beds
Aven Manor*	Yellowknife	Yellowknife	29	0
Aven Cottages – Territorial Dementia Facility*	Yellowknife	Yellowknife	24	4
Stanton Extended Care Unit*	Yellowknife	Yellowknife	10	2
Jimmy Erasmus Senior's Home	Behchoko	Tlicho	7	1
H.H. Williams*	Hay River	Hay River	10	0

[33] Based on Request for Proposals PM014816 and discussions with Department Director of Infrastructure and Planning. Does not include respite or palliative care beds.

Facility	Location	HSSA	Full-Time LTC Beds	Respite/ Palliative Beds
Woodland Manor*	Hay River	Hay River	15	0
Northern Lights Special Care Home*	Fort Smith	Fort Smith	26	2
Fort Simpson Long Term Care	Fort Simpson	Dehcho	17	1
Inuvik Regional Long Term Care*	Inuvik	Beaufort-Delta	22	3
Total			**160**	**13**

* Accredited

Figure 9: Map Showing Current Distribution of LTC Beds



MNP LLP

Figure 9 shows the distribution of LTC beds by HSSA as well as the number of LTC beds per 1,000 population aged 70 plus based on 2011 population figures. The number of LTC beds per 1,000 population aged 70 plus in the NWT is 124. The FSHSSA has a ratio much higher than that of the rest of the NWT at 188 LTC beds per 1,000 population 70 plus followed by the YHSSA at 173 beds per 1,000 population 70 plus. There are currently no LTC beds in the SHSSA. The TCSA has a ratio well below that of the rest of NWT at 73 LTC beds per 1,000 population 70 plus as does the BDHSSA at 84 beds per 1,000 population 70 plus.

Looking forward, two new LTC facilities are in the process of being developed including an 18 bed facility in Behchoko (16 LTC beds plus 2 beds for respite/palliative care) and another 18 bed LTC facility in Norman Wells (16 LTC beds plus 2 beds for respite/palliative care). However, the new 18 bed facility in Behchoko will replace the existing Jimmy Erasmus Senior's home that currently has 7 LTC beds and 1 respite bed. The development of the new 18 beds in Norman Wells is consistent with the philosophy to provide LTC as close to home as possible and to develop capacity in each region to provide LTC. There are currently no LTC beds in the Sahtu region.

There are also plans to replace the 10 beds at the H.H. Williams facility in Hay River with the addition of 10 new beds at the Woodland Manor (8 LTC beds plus 2 beds for respite/palliative care).[34] These beds have been included in the future LTC bed base for projecting the LTC bed requirements from 2016 to 2031 (Section 4.0).

Avens has recently developed a business plan for a new LTC bed facility that includes 45 LTC beds. These plans include replacement of the 29 LTC beds that currently exist. Additionally it includes a net increase of 16 LTC beds including 10 extended care beds to replace the 10 extended care beds at Stanton, 3 palliative care beds, and additional beds for contingency requirements. To date, this business plan has not been approved by the Department.

Overall, with the developments of the two new 18 bed facilities, the elimination of 8 beds at Jimmy Erasmus and the replacement of the 10 beds at H.H. Williams at Woodland Manor, there is a 28 bed increase in the total number of LTC beds from 173 to 201. This includes 183 full-time LTC beds and 18 beds for respite/palliative care.

3.2.2 Utilization of LTC Beds

Figure 10 shows the utilization of LTC beds in the NWT by each LTC facility for the 2011/12 and 2012/13 fiscal years. The occupancy of all LTC beds in the NWT was 97.1% in 2011/12 and 96.0% in 2012/13. Eight of the nine LTC facilities had occupancy rates over 95% in 2011/12 and seven of the nine facilities had occupancy rates over 95% in 2012/13. The Stanton Extended Care Unit (ECU) had the lowest occupancy of all facilities in both years with rates of 91.1% in 2011/12 and 75.9% in 2012/13. The Fort Simpson LTC facility had an occupancy rate of 94% in 2012/13.

[34] Based on discussions with Director of Infrastructure and Planning.

Figure 10: Occupancy of LTC Facilities in the NWT in 2011/2012 and 2012/13[35]

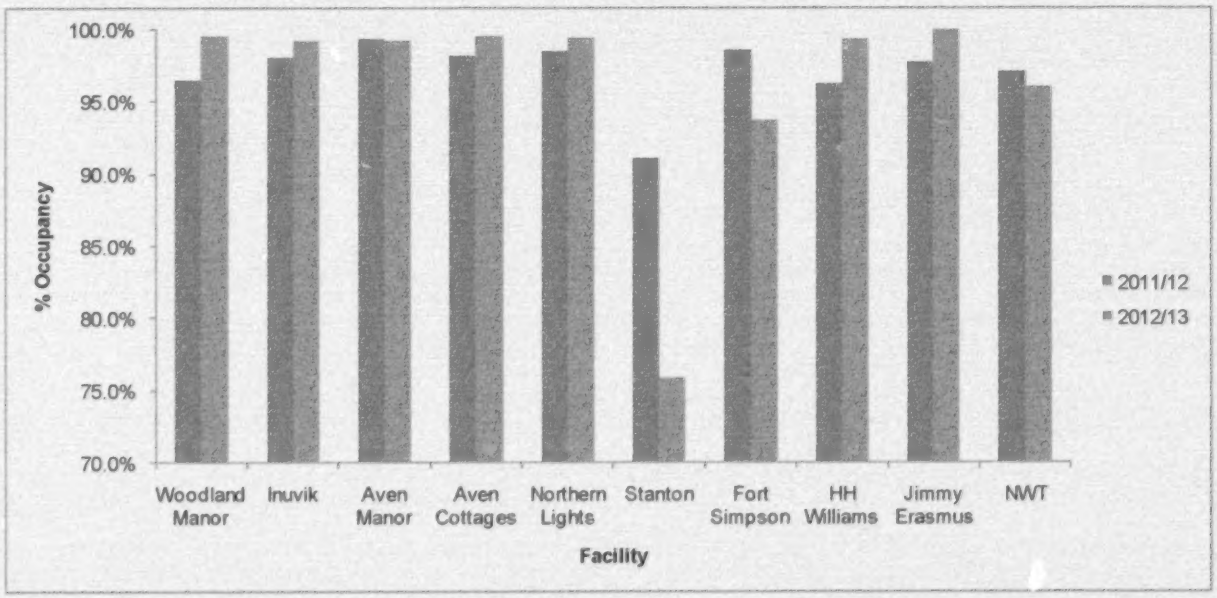


Figure 11 shows the average age of residents occupying LTC beds by LTC facility in the NWT. The average age of residents was 77 or over in all LTC facilities in the NWT except the Stanton Extended Care Unit where the average age was 67 in 2010/11 and 65 in 2012/13. Overall, the vast majority of residents in all facilities were aged 70 years and older except for the Stanton ECU which had a wide range of residents aged from 37 to 87 years old over the two year period.

Figure 12 shows that the average length of stay (LOS) of residents occupying beds by LTC facility in the NWT. Aven Cottages appears to have the lowest average LOS. However, this is more a reflection of these beds opening in the 2010/11 fiscal year and not how long residents occupy these beds. The patients at the Stanton ECU had a lower average LOS than residents at other LTC facilities. The average LOS at the remaining facilities was as short as 2.3 years at H.H Williams and as high as 5.5 years at Inuvik.

[35] Based on data provided by the Department.

Figure 11: Average Age of Residents Occupying Beds in LTC Facilities in the NWT[36]

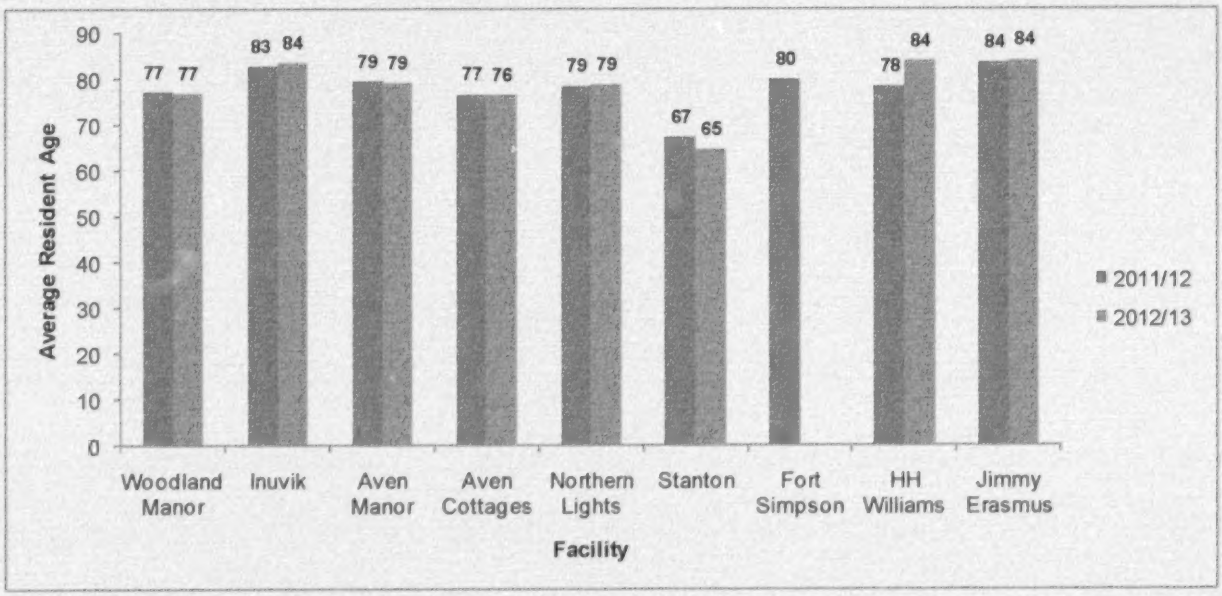
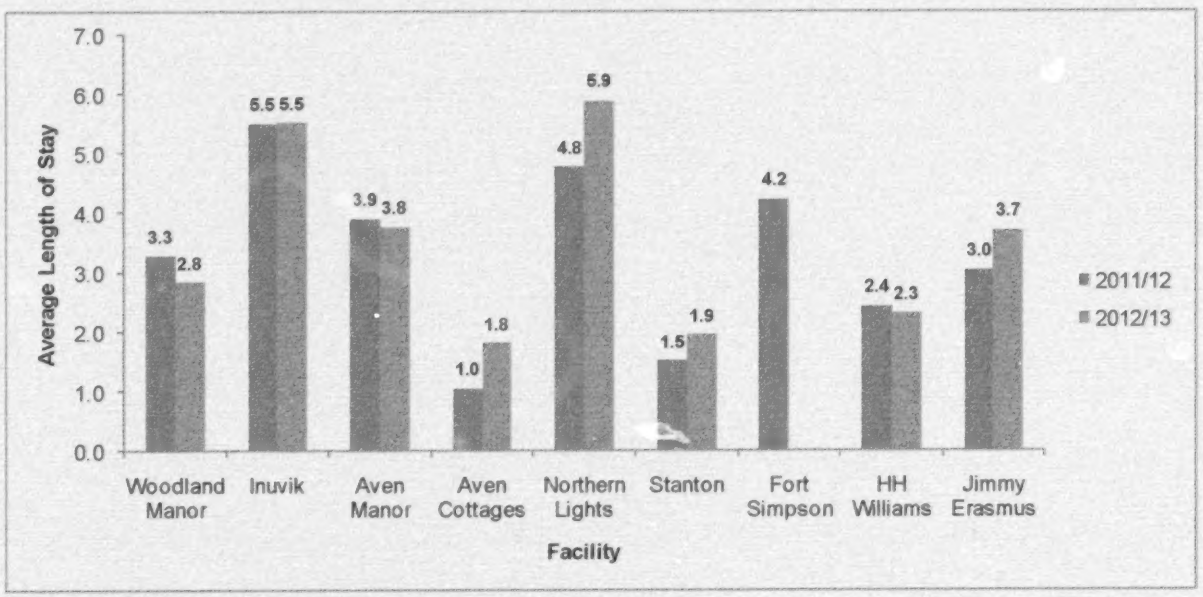


Figure 12: Average Length of Stay of Residents in LTC Facilities in the NWT[37]



[36] Based on data provided by the Department. Note that no data was available for the Fort Simpson LTC facility for 2012/13.

[37] Based on data provided by the Department. Note that no data was available for the Fort Simpson LTC facility for 2012/13.

Figure 13: Average Level of Care of Residents Occupying Beds in LTC Facilities in the NWT[38]

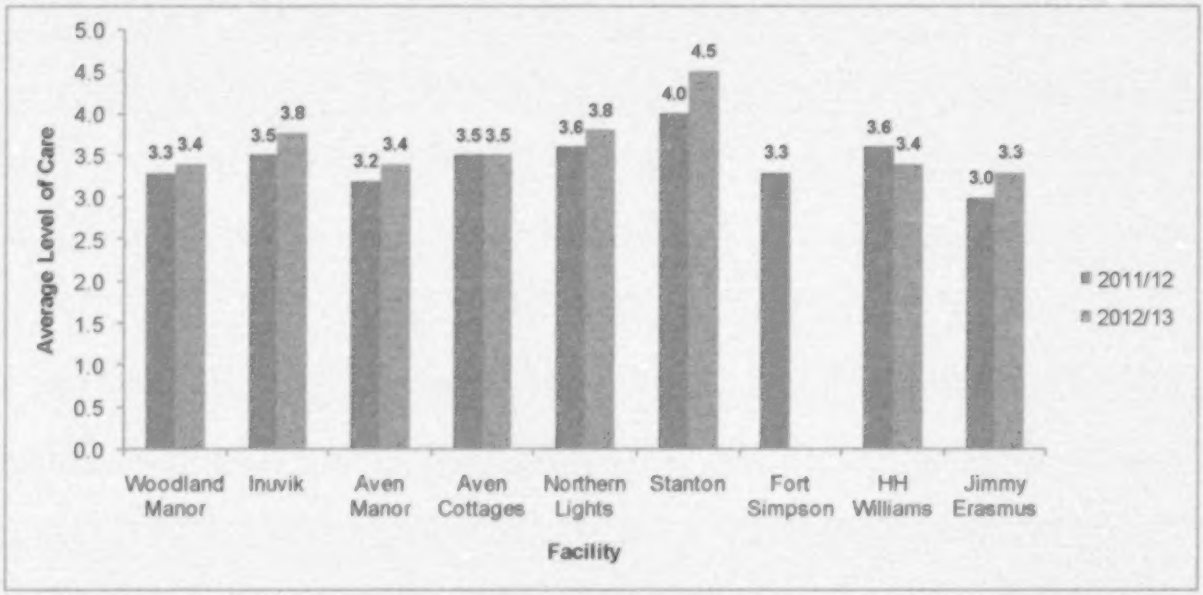


Figure 13 shows the average level of care (LOC) of residents occupying beds by LTC facility in the NWT. Over the 2011/12 and 2012/13 fiscal years the average LOC ranged was 3.2 to 3.8 for all LTC facilities except the Stanton ECU, which had an average LOC of 4.0 in 2011/12 and 4.5 in 2012/13. The average levels of care observed for most LTC facilities are consistent with the levels of service framework suggested for the NWT Continuum of Care (see Figure 2) which suggests that individuals requiring level 3 or level 4 services are appropriate for LTC.

3.2.3 Territorial Admissions Committee

The Territorial Admissions Committee (TAC) started in October 2009. TAC was established to streamline the application process for admission into the nine LTC facilities. It acts as a single point of entry for application and coordinates waitlist and admission of applicants to LTC facilities.

The committee is made up of eight members including[39]:

- The TAC Chair who is the Manager of Continuing Care and Health System Planning.
- Four HSSA representatives with responsibility for LTC facilities and services (on a rotational basis).
- Two Department staff with responsibility for LTC, home care or Supported Living.
- One public representative.

The TAC determines the need and priority for LTC based on a review of the patient assessment and using a priority screening tool. Assessments are conducted using the Continuing Care Assessment

[38] Based on data provided by the Department. Note that no data was available for the Fort Simpson LTC facility for 2012/13.
[39] Territorial Admissions Committee Orientation Binder. Revised April 2013.

Package (CCAP), a comprehensive assessment package that includes a general assessment of clients based on 27 domains as well as the medical/surgical history, social history, and medication record of patients. The CCAP also includes a placement plan section that includes service planning and placement options for clients. The CCAP contains approximately 70 pages of forms to complete. The CCAP for each patient is reviewed by committee members and the priority screening tool determines the priority and level of care of clients based on the assessed rating for 13 risk factors.

If a LTC bed is not available in the client's home community/region, the TAC will offer interim placement in another community/region. If accepted the client will be priority for the next available bed. Interim placement is often declined and clients remain in their community in an alternate level of care bed or at home with additional support from family and home care.

Overall, there was a perception that the development of the TAC was a good decision and that the committee has helped improve placement of residents into LTC beds in the NWT. Key informants perceived that the TAC uses a transparent and formalized process for placing patients into LTC beds and for recommending patients for home care services.

A number of key informants noted that the CCAP assessment tool is cumbersome and time consuming to complete as well as time consuming to review for TAC members. The CCAP is felt to lack credibility in regard to evidence-based decision support and an improved assessment tool is needed. A comprehensive health assessment is the backbone of the territory's Single Entry Access system. The Inter-RAI Home Care (RAI-HC) tool was suggested as an improved assessment tool for placements that could streamline the process and allow for better data collection.

Some key informants also noted that the communication of waitlists by the TAC to the HSSAs could be improved. It was suggested that the HSSAs who had representation on the TAC were more informed of the waitlist situation than those HSSAs who did not have representation on the committee.

3.2.3.1 TAC Activity and Waitlist Data

Table 12 shows the number of people placed into each facility from 2009/10 to 2012/13. Note that 2010/11 data includes applications from October 2009 to March 31, 2010. Over this time span, there were a total of 164 people placed into LTC facilities in the NWT by the TAC. The average waiting time for residents was approximately 74 days. There are currently 11 people awaiting placement into a LTC facility who submitted an application in the timeframe of February 25, 2011 (longest applicant awaiting placement) through to March 18, 2013 as well as two people awaiting placement who submitted applications in the current fiscal year on April 18, 2013.

Table 12: Placement Data by Facility from 2009/10 to 2012/13[40]

Facility	2009/10	2010/11	2011/12	2012/13	Total
Aven Manor	6	12	7	7	**32**
Aven Cottages – Territorial Dementia Facility	13	14	5	5	**37**
Stanton Extended Care Unit	4	6	4	2	**16**
Jimmy Erasmus Senior's Home	0	2	1	0	**3**
H.H. Williams	4	2	4	2	**12**
Woodland Manor	2	6	8	2	**18**
Northern Lights Special Care Home	2	5	2	6	**15**
Fort Simpson Long Term Care	2	2	3	2	**9**
Inuvik Regional Long Term Care	5	5	5	7	**22**
Total	**38**	**54**	**39**	**33**	**164**
Average Waiting Time (Days)	100.47	59.35	65.23	76.84	**73.82**
Currently Awaiting Placement	0	1	2	8	**11**

Table 13 summarizes the assessed level of care of applicants by the TAC. Of the 175 applicants assessed from October 2009 to March 31, 2013; 66 (38%) were assessed at level 3, 102 (58%) were assessed at level 4, and 7 (4%) were assessed at level 5. The average assessed level of care of the 175 applicants assessed by the TAC was 3.66. This shows that all of the applicants placed into or awaiting placement into LTC facilities by the TAC are appropriate for placement into LTC based on the levels of service framework suggested for the NWT Continuum of Care (see Figure 2).

Table 13: Summary of Assessed Level of Care by the TAC[41]

Level of Care	2009/10	2010/11	2011/12	2012/13	Total
3	12	25	11	18	**66**
4	23	27	29	23	**102**
5	3	3	1	0	**7**
Total	**38**	**55**	**41**	**41**	**175**
Average Level of Care	3.76	3.60	3.76	3.56	**3.66**

[40] Based on data provided by the Department. Note that the 2009/10 fiscal year data includes data from October 2009 to March 31, 2010.
[41] Based on data provided by the Department.

Table 14: Summary of Assessed Care Type by the TAC[42]

Type of Care	2009/10	2010/11	2011/12	2012/13	Total
LTC	20	32	32	33	**117**
Dementia Care	14	17	4	2	**37**
Extended Care	4	4	4	2	**14**
LTC/Dementia	0	2	1	4	**7**
Total	**38**	**55**	**41**	**41**	**175**

Table 14 shows that 117 (67%) of applicants were assessed as requiring LTC, 37 (21%) were assessed as requiring dementia care, 7 were assessed as requiring LTC and dementia care, and 14 (8%) were assessed as requiring extended care.

3.2.3.2 Impact of Public Guardianship Services

The ability to consent for Continuing Care services is becoming an increasingly pressing issue. For example the TAC is unable to review LTC and SL application assessments without clients' consent to share their confidential information with the committee. Entry to a client home and provision of home care support and nursing services is also contingent on valid consent.

Application can be made to The Office of the Public Guardian for guardianship services for adults who do not have the ability to make personal decisions about their own affairs. The Office of the Public Guardian provides information and support to help private guardians or substitute/co-decision makers fulfill the duties and responsibilities of this role. Information about arranging for personal or advanced directives is also provided. The *Personal Directives Act* allows NWT residents, 19 years of age and older, to provide in advance, instructions about their health care and personal matters. The Act also allows for the designation of a person of their choice to act for them in the event of their own incapacity, a process which would greatly expedite our ability to process applications and requests for service.

A recent informal survey of LTC facilities revealed that it takes from 8 months to 2 years, or more in cases where complications of family ties and residency of close family members arise, to complete guardianship after admission. For some the process was started well before admission so it is difficult to estimate the total time for the process.

3.2.4 Long-Term Care Staffing Levels

The Department just recently started using a standard of 3.6 hours of direct care per resident to budget for its LTC staffing requirements in most facilities except for the Stanton ECU and Aven Cottages. This ratio has been used as a standard in other jurisdictions such as the Province of Manitoba.[43] The Department also uses a standard ratio of 20% nursing staff (Registered Nurses (RNs) or Licensed Practical Nurses (LPNs)) and 80% Resident Care Aide (RCA) to budget for its LTC staffing in most facilities except the Stanton ECU and Aven Cottages. The staffing standard for LTC was developed by the Department based on research of other jurisdictions and an in-depth risk analysis that substantiated

[42] Based on data provided by the Department.
[43] 2012 Continuing Care Strategy. Manitoba Health. August 2012.

this standard provides for an adequate quality of care and minimized potential for risk management issues.[44]

Table 15: Current and Proposed Hours of Direct Care for LTC Facilities[45]

Facility	Current Hours of Direct Care	Proposed Hours of Direct Care	Variation
Aven Manor*	2.5	3.6	-1.1
Aven Cottages – Territorial Dementia Facility*	3.9	3.7	0.2
Stanton Extended Care Unit*	6.6	n/a	n/a
Jimmy Erasmus Senior's Home	6.3	3.6	2.7
H.H. Williams*	4.2	3.6	0.6
Woodland Manor*	4.6	3.6	3.0
Northern Lights Special Care Home*	4.2	3.6	0.6
Fort Simpson Long Term Care	2.8	3.6	-0.8
Inuvik Regional Long Term Care*	3.8	3.6	0.2

There are two facilities that are currently staffed below 3.6 hours of direct care - Aven Manor and Fort Simpson LTC (Table 15). The remaining LTC facilities are staffed above 3.6 hours of care. Aven Cottages is staffed and currently funded at 3.9 hours of direct care.

Table 16 shows the current staffing levels and those proposed under a model of 3.6 hours of direct care and a ratio of 20% RN/LPN to 80% RCA. Most of the facilities, with the exception of Aven Manor and Jimmy Erasmus, are currently staffed with a higher ratio of nurses to RCAs. Overall, the current ratio is 37% RN/LPN and 63% RCA. In comparing the current staffing mix to the proposed staffing mix, there is currently a total surplus of 18.7 FTE of nursing staff in all facilities combined and a deficit of 17.2 FTE of RCA staff.

[44] Based on Minister's Briefing/HSS for Northern Lights Special Care Home Staffing. Territorial Health Services June 18, 2013.
[45] Based on data provided by the Department.

Table 16: Current and Proposed Staffing Levels for NWT LTC Facilities[46]

Facility	RN/LPN FTE			RCA FTE		
	Current	Proposed	Variation	Current	Proposed	Variation
Aven Manor	2.0 (15%)	3.7 (20%)	-1.7	11.2 (85%)	14.9 (80%)	-3.7
Aven Cottages – Territorial Dementia Facility	4.1 (21%)	4.1 (21%)	0	15.4 (79%)	15.4 (79%)	0
Jimmy Erasmus Senior's Home	0 (0%)	1.0 (20%)	-1.0	9.0 (100%)	4.1 (80%)	4.9
H.H. Williams	8.0 (100%)	1.3 (20%)	6.7	0 (0%)	5.4 (80%)	-5.4
Woodland Manor	7.0 (56%)	1.9 (20%)	5.1	5.5 (44%)	7.7 (80%)	-2.2
Northern Lights Special Care Home	7.0 (37%)	3.6 (20%)	3.4	12.0 (63%)	14.3 (80%)	-2.3
Fort Simpson Long Term Care	5.0 (56%)	2.3 (20%)	2.7	4.0 (44%)	9.2 (80%)	-5.2
Inuvik Regional Long Term Care	7.0 (41%)	3.5 (20%)	3.5	10.0 (59%)	13.3 (80%)	-3.3
Total	**40.1 (37%)**	**21.4 (20%)**	**18.7**	**67.1 (63%)**	**84.3 (80%)**	**-17.2**

3.2.5 Long-Term Care Funding

Each LTC facility receives operational funding from the Department. Table 17 shows the funding budgeted for and actual spending for each LTC facility for the 2010/11 and 2011/12 fiscal years. There was an overall deficit from operations for all facilities combined in the territory for each fiscal year including $1.1 million in 2010/11 and approximately $950,000 in 2011/12. Overall, the budget for all LTC facilities in the NWT in 2011/12 increased by 11% compared to the budget for 2010/11 and the actual spending by all LTC facilities increased by 10%. There was total spending of approximately $18.9 million by LTC facilities in the NWT in 2010/11 and total spending of approximately $20.7 million in 2011/12.

Table 17: LTC Facility Funding and Actual Funding

Facility	2010/11			2011/12		
	Budget ($)	Actual ($)	Variation ($)	Budget ($)	Actual ($)	Variation ($)
Aven Manor	2,742,223	2,742,224	(1)	2,805,223	2,911,223	(106,000)
Aven Cottages – Territorial Dementia Facility	3,503,000	3,503,000	0	3,503,000	3,502,998	2
Jimmy Erasmus Senior's Home	1,276,950	1,497,760	(220,810)	1,333,847	1,605,029	(271,182)
H.H. Williams	1,293,450	1,041,738	251,712	1,128,650	999,412	129,238
Woodland Manor	1,642,300	1,546,204	96,096	1,660,940	1,587,780	73,160
Northern Lights Special Care Home	2,220,393	2,493,072	(272,679)	2,960,897	3,550,366	(589,469)
Fort Simpson Long Term Care	1,235,809	1,356,036	(120,227)	1,285,150	1,620,614	(335,464)
Inuvik Regional Long Term Care	1,937,196	2,901,098	(963,902)	3,103,522	3,042,030	61,492
Total	**17,747,963**	**18,858,753**	**(1,110,790)**	**19,738,011**	**20,687,283**	**(949,272)**

[46] Based on data provided by the Department.

The deficits observed for most facilities in 2010/11and 2011/12 are largely being driven by the costs associated with overtime for coverage of sick, annual and special leave; vacancies and weekend shifts. The deficit observed for Aven Manor in 2011/12 was noted to be due to increases from collective agreements with staff. This was addressed through an increase in funding in 2012/13.

In 2011/12, the Northern Lights Special Care Home operated 21 beds at a deficit of $589,469 and had actual costs that were higher than Aven Manor which operates 29 beds and Inuvik which operates 25 beds (22 LTC and 3 respite). A review of the expenditures at Northern Lights is being considered by the Department.

3.2.6 Key Informant Perceptions of LTC Service Delivery

A summary of notable perceptions about LTC services are provided in the bulleted points below.

- There are differences of opinion in the NWT regarding the delivery of LTC services. Some strongly believe that LTC services should be provided close to home, while others believe the costs and feasibility associated with delivering LTC services in this manner may outweigh the potential benefits.
    - Some key informants noted the challenge families who had loved ones staying in a LTC facility located in a different community then their residence face because of the travel requirement and costs to visit them.
    - There is a growing desire as well as an expectation by residents in the NWT to receive services in their home community. There was some concern noted that this will place greater demands on other services along the continuum of care such as home and community care, respite care, and SL. There was also concern that the new LTC beds planned for Norman Wells would not be occupied for this same reason.

- Another trend impacting service delivery that was noted by some key informants was the desire for people to remain in their homes and communities as long as possible. There is less desire from elders to live in an institutional setting. The expected result of this is that the level of care of residents placed into LTC homes will be higher and that length of stays will decrease.

- There is a need for consistent standards for LTC programs.
    - The current standards developed in 2000 are felt to be facility specific and consistent standards are required to facilitate consistent service delivery.
    - Draft Continuing Care standards are being finalized which includes LTC standards.
    - It was suggested that consistency could be achieved by ensuring that all facilities are accredited. Currently all but two facilities have been accredited.

- Staff training needs to be current for existing staff to ensure that they are delivering services appropriately. There will also be a need to train and recruit sufficient staff for existing facilities that are not staff at 3.6 hours of direct care as well as the new facilities planned in Behchoko and Norman Wells. Some training has already occurred for the facility on Behchoko; the TSCA contracted Aurora College to come into the community to provide training and this approach was felt to be successful. The Department is considering this approach for Norman Wells.

- In general, staff recruitment and retention outside of Yellowknife is a challenge consistent with the staffing issues observed for HCC.

- There is a greater need for physicians and expertise to provide dementia support. There is currently only 1 physician who provides this support. It was also noted that better planning was required to support physician absences and turnover.

- There is a need for more culturally appropriate service delivery in facilities located in communities and regions with a higher Aboriginal population. An example of culturally appropriate services delivery is having meal selections and programming that is aligned with the traditions of Elders residing in communities.

- Data collection and reporting was also noted to be a challenge for LTC. There is an identified need for a more simple and consistent method of data collection. Inter-RAI has a module for LTC that would provide data to monitor outcome indicators in addition to utilization data.

3.3 Extended Care

Extended care services in the NWT are provided by the 12-bed Extended Care Unit at the Stanton Hospital in Yellowknife. A total of 10 beds have currently been allocated for extended care, 1 bed for palliative care and 1 bed for respite care. In 2010/11 and 2011/12 the unit operated with 11 extended care beds. The ECU provides services to adult residents requiring long-term residential care with complex physical or cognitive needs.

All extended care beds have been placed at Stanton because they must be located in a tertiary care centre and Stanton is the only tertiary care centre in the territory. The occupancy of the ECU beds was 60% in 2010/11, 91% in 2011/12, and 76% in 2012/13 (Table 18). The low occupancy in 2010/11 was due to the transfer of patients to Aven Cottages when it opened. The average age of patients at the Stanton ECU was 67 in 2011/12 and 65 in 2012/13. This is significantly lower than the average age of residents in the other LTC facilities in the territory and is a reflection of the diversity of this patient population.

Table 18: Occupancy of Stanton ECU Beds[47]

Fiscal Year	Occupancy
2010/11	60%
2011/12	91%
2012/13	76%

There was a total of 18 people were placed into the Stanton ECU since the start of the TAC including 4 in 2009/10, 6 in 2010/11, 6 in 2011/12 and 4 in 2012/13 (Table 19). The average level of care of the 16 people placed into the Stanton ECU was 4.3 and ranged from 3 to 5. The average level of care of residents occupying extended care beds on the ECU in was 4.0 in 2011/12 and 4.5 in 2012/13 and ranged from 2 to 5. The TAC received an assessment on a SL client paced Out of Territory whose care needs had increased; and according to the information provided by the Agency he was assessed at a level 5. Stanton ECU provided the TAC with an updated CCAP that resulted in the client being assessed at Level 2. The client remained at Stanton ECU awaiting SL placement within the NWT. Although it appears that not all residents are admitted at a level 5, there are some residents admitted at a high level 4.

[47] Based on data provided by the Department.

Table 19: Admissions to Stanton ECU[48]

Fiscal Year	# Admitted	Average Level of Care
2009/10	4	4.75
2010/11	6	4.5
2011/12	4	4
2012/13	2	3.5
Total	**16**	**4.3**

Currently, the ECU at Stanton is staffed to provide 6.6 hours of direct care per patient based on 95% occupancy. This is nearly twice as high as the 3.6 hours of direct care per resident in the other LTC facilities. The ECU is staffed with 10 FTE Nurses (5 FTE RNs and 5 FTE LPNs) and 1.75 FTE Nursing Aides (Table 20).

Table 20: Staffing Mix of Stanton Extended Care Unit

Position	FTE	% of Total Staff
RN	5	42.5%
LPN	5	42.5%
Nursing Aide	1.75	15.0%
Total	**11.75**	**100%**

3.3.1 Key Informant Perceptions of Extended Care

A summary of notable perceptions about Extended Care services are provided in the bulleted points below.

- Extended care beds in the NWT need to be located at Stanton due to the complex needs of these patients (requirements for specialized equipment, respiratory therapy). However, some key informants noted that the Stanton ECU does not provide a home-like environment for patients, and if possible, the beds might be better located at a LTC facility like Avens.
- Beds were occupied by a diverse patient population (FASD, brain injuries) and that it was difficult to project the future needs of this population. Some key informants noted that an assessment is required of what is being provided to ECU patients and that the NWT needs to better define what services are being provided for extended care.
- One individual noted that the current bed number for extended care beds appears to be appropriate because there is not a long waiting list for beds at the ECU while another noted it is currently hard to determine if these beds are being occupied by the appropriate patient population.
- The redevelopment of Stanton provides an opportunity to determine the most appropriate location for ECU beds.

[48] Based on data provided by the Department.

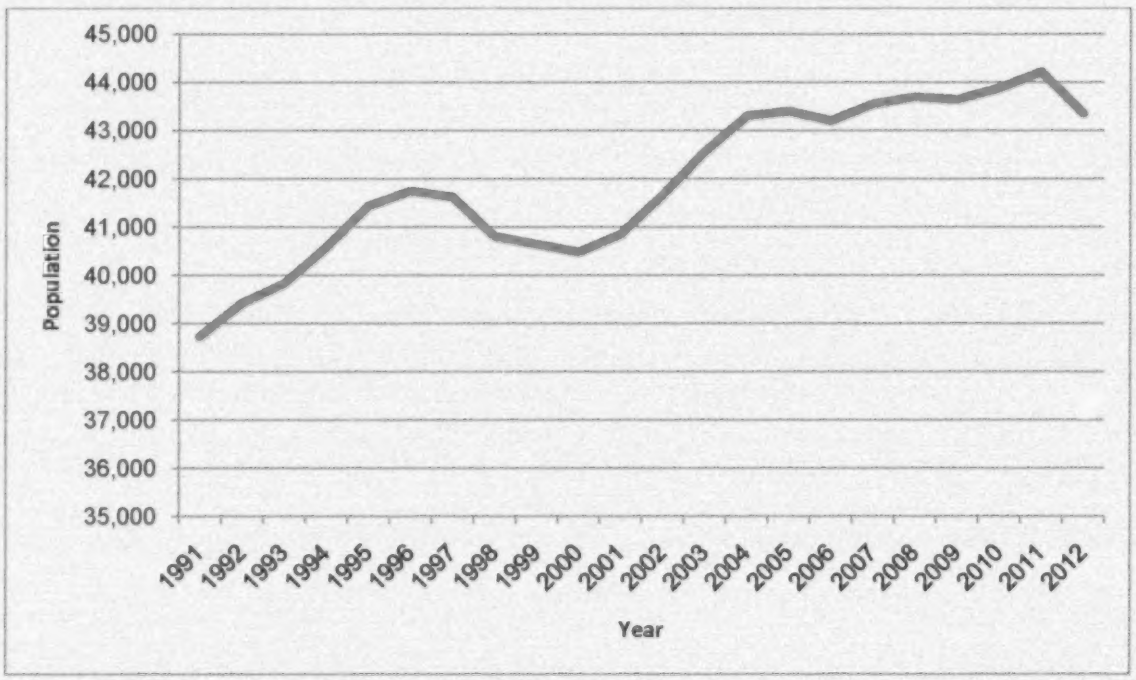
4.0 Population Projections and Long-Term Care Bed Requirements to 2031

4.1 Population Projections for 70 Plus Age Group

Population projections were prepared to the year 2031 by the NWT Bureau of Statistics. Specifically, population projections were developed for each community and broken down by age group (including those aged 70 years and older) and ethnicity.

The population projections were developed based on 2011 population estimates for the NWT. The projections incorporate three components of population change (fertility, mortality, and migration) and use historical growth trends (Figure 14) to determine the projections for the next 20 years to 2031. Information in the projections was suppressed for communities with a population of 50 or less or if the number of people in any age group was 10 or less.

Figure 14: Growth Trends used in Developing Population Projections to 2031[49]



To determine the projected population of those aged 70 plus in each region, MNP grouped the communities in each region together and then added the projected population of those aged 70 plus. Table 21 summarizes the population projections aged 70 plus by region. Overall, the population of those aged 70 plus is projected to triple for the NWT from 1,393 in 2011 to 4,418 in 2031 and is projected to at least double in all regions except for the Tlicho region. The largest growth for the 70 plus age group is projected in the Yellowknife HSSA at 449%. Figure 15 demonstrates the growth trend of those aged 70

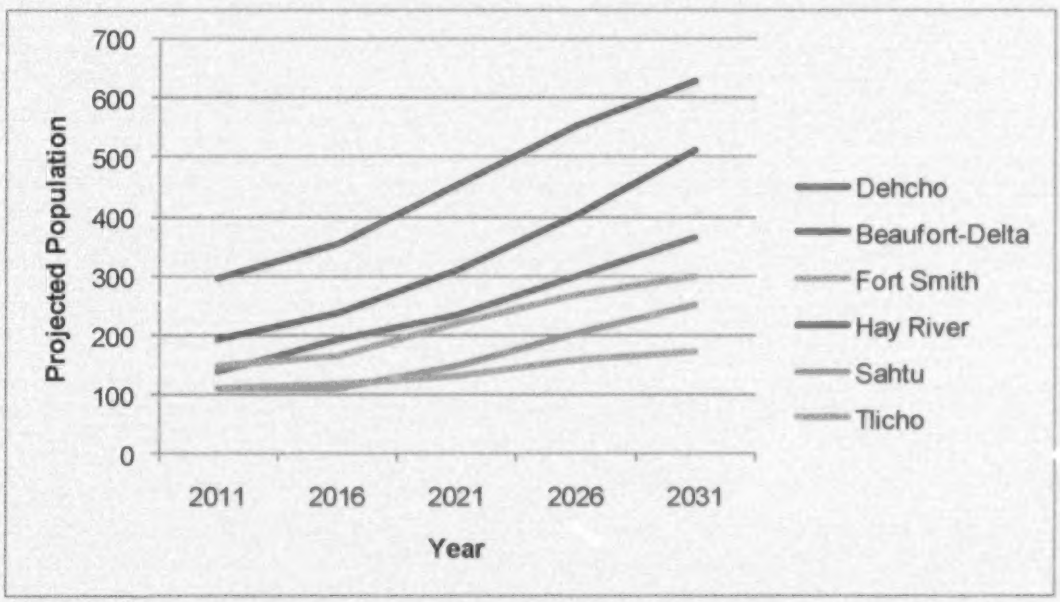
[49] Developed and provided by the NWT Bureau of Statistics on July 8, 2013.

plus in the six regions outside of Yellowknife from 2011 to 2031 and Figure 16 demonstrates the projected growth trend for the Yellowknife region and the NWT as a whole.

Table 21: Population Projections for the 70 plus Age Group in each HSSA to 2031[50]

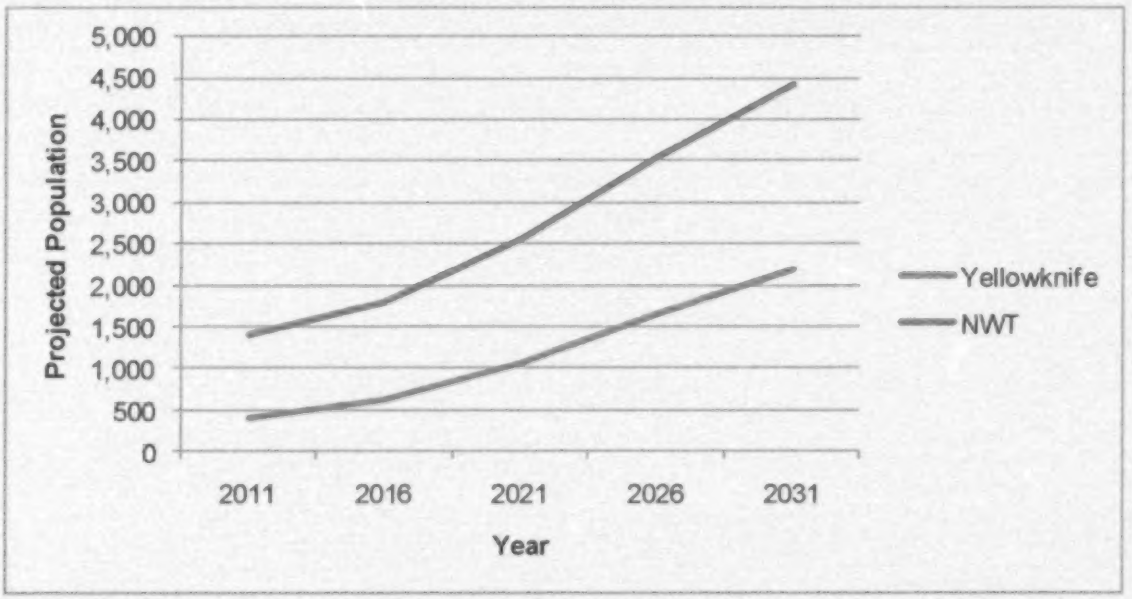
Region	2011	2016	2021	2026	2031	% Growth 2011 - 2031
Beaufort-Delta	296	354	454	554	630	113%
Dehcho	139	191	233	300	363	161%
Fort Smith	149	165	220	269	299	101%
Hay River	192	237	309	403	511	166%
Sahtu	109	112	147	204	252	131%
Tlicho	109	117	130	157	173	59%
Yellowknife	399	611	1,058	1,643	2,190	449%
NWT Total	**1,393**	**1,787**	**2,551**	**3,530**	**4,418**	**217%**

Figure 15: Projected Population Growth Trends for 70 plus Age Group by HSSA[51]



[50] Based on the population projections provided by the NWT Bureau of Statistics on June 10, 2013.
[51] Based on the population projections provided by the NWT Bureau of Statistics on June 10, 2013. Does not include Yellowknife HSSA.

Figure 16: Projected Population Growth Trend for Yellowknife HSSA and NWT.[52]



4.2 Long-Term Bed Projections to 2031 in the NWT

4.2.1 LTC Bed Projection Models

A number of approaches have been developed to project the requirements for LTC beds in provinces and territories across Canada. Many approaches take into account a philosophy of "aging in place" and reflect the shift from relying on LTC facilities to provide seniors care, to providing as much services as possible in the community and/or in the home.

In 2002, the Manitoba Centre for Health Policy developed a ratio of 110 beds per 1,000 population (110/1000 ratio) aged 75 years and older to estimate LTC bed requirements.[53] This ratio was established as a midpoint between two estimates. The first was a continuation of an observed downward trend in usage observed in the ten years prior to the study. This trend was attributed to potential residents staying healthier longer and/or remaining in their homes longer. The second was a forward projection based on the actual usage over a 13 year period. The 110/1000 ratio was expected to fairly reflect the demand for personal care home beds by 2020. A recent study by the Manitoba Centre for Health Policy found that the 110/1000 ratio is still fairly reflective of the demand for LTC beds to the year 2020.[54]

Three different LTC bed projection models were considered to estimate the requirements for LTC beds in each region in the NWT.[55] All three models are based on a 110 bed per 1,000 population aged 70 years and older ratio, but two of the models take into account a larger shift towards HCC in the future. The

[52] Based on the population projections provided by the NWT Bureau of Statistics on June 10, 2013.
[53] Estimating Personal Care Home Bed Requirements. Manitoba Centre for Health Policy. December 2002.
[54] Projecting Personal Care Home Bed Equivalent Needs in Manitoba through 2036. Manitoba Centre for Health Policy. October 2012.
[55] Note that the requirements for STHA were included with the YHSSA.

110/1000 ratio is also slightly lower than the existing LTC bed to population ratio for individuals aged 70 plus in the NWT (see Section 3.2.1 above) and is also similar to the 115 beds per 1,000 aged 70 plus and 95% occupancy (or a ratio of 109.25/1000 after accounting for the 95% occupancy) used in the 2009 planning study for the NWT.[56] A description of the three LTC bed projection models considered follows below.

LTC Bed Projection Model 1: This model applies the 110/1000 ratio to the population projections prepared by the NWT Bureau of Statistics for the 70 plus age group in each region (see Section 4.1 above) to estimate the LTC bed requirements in each region.

LTC Bed Projection Model 2: This model starts with the 110/1000 ratio as a starting point in 2011 for estimating the requirements for LTC beds and then decreases this ratio by 0.59% per year to reflect a more modest shift towards expanded HCC and SL options in each community.[57] The ratio was updated every 5 years (2016, 2021, 2026, and 2031) to correspond with the population projections prepared by the NWT Bureau of Statistics. The updated ratios were applied to the population projections for the 70 plus age group in each region to estimate the LTC bed requirements in each region.

LTC Bed Projection Model 3: This model starts with the 110/1000 ratio as a starting point in 2011 for estimating the requirements for LTC beds and then decreases this ratio by 1.06% per year to reflect a medium shift towards expanded HCC and SL options in each community.[58] The ratio was updated based every 5 years (2016, 2021, 2026, and 2031) to correspond with the population projections prepared by the NWT Bureau of Statistics. The updated ratios were applied to the population projections for the 70 plus age group in each region to estimate the LTC bed requirements in each region.

Table 22 shows the ratios of LTC beds for each projection model that MNP used to estimate the LTC bed requirements in each of 2011, 2016, 2021, 2026 and 2031.

Table 22: LTC Bed Ratio per 1,000 Population Aged 70 Plus for each Projection Method

LTC Bed Projection Model	LTC Beds per 1,000 Population 70 Plus				
	2011	2016	2021	2026	2031
1	110	110	110	110	110
2	110	107	104	101	98
3	110	104	99	94	89

4.2.2 Estimated LTC Bed Requirements to 2031 for each HSSA

Table 23 provides a summary of the LTC bed requirements for each HSSA using each of the three projection models described above. It is recommended that projection model 3 be used for LTC planning in the Beaufort-Delta, Fort Smith, Hay River and Yellowknife HSSAs because they have larger regional centres that provide greater access to supports such as hospitals that will assist elders to age closer to home and in the community. It is recommended that projection model 2 be used for the LTC bed planning for the Dehcho, Sahtu, and Tlicho HSSAs because they have smaller communities that do not have access to as many supports to allow elders to age close to home. The LTC bed projections from the recommended model for each HSSA have been bolded in Table 23.

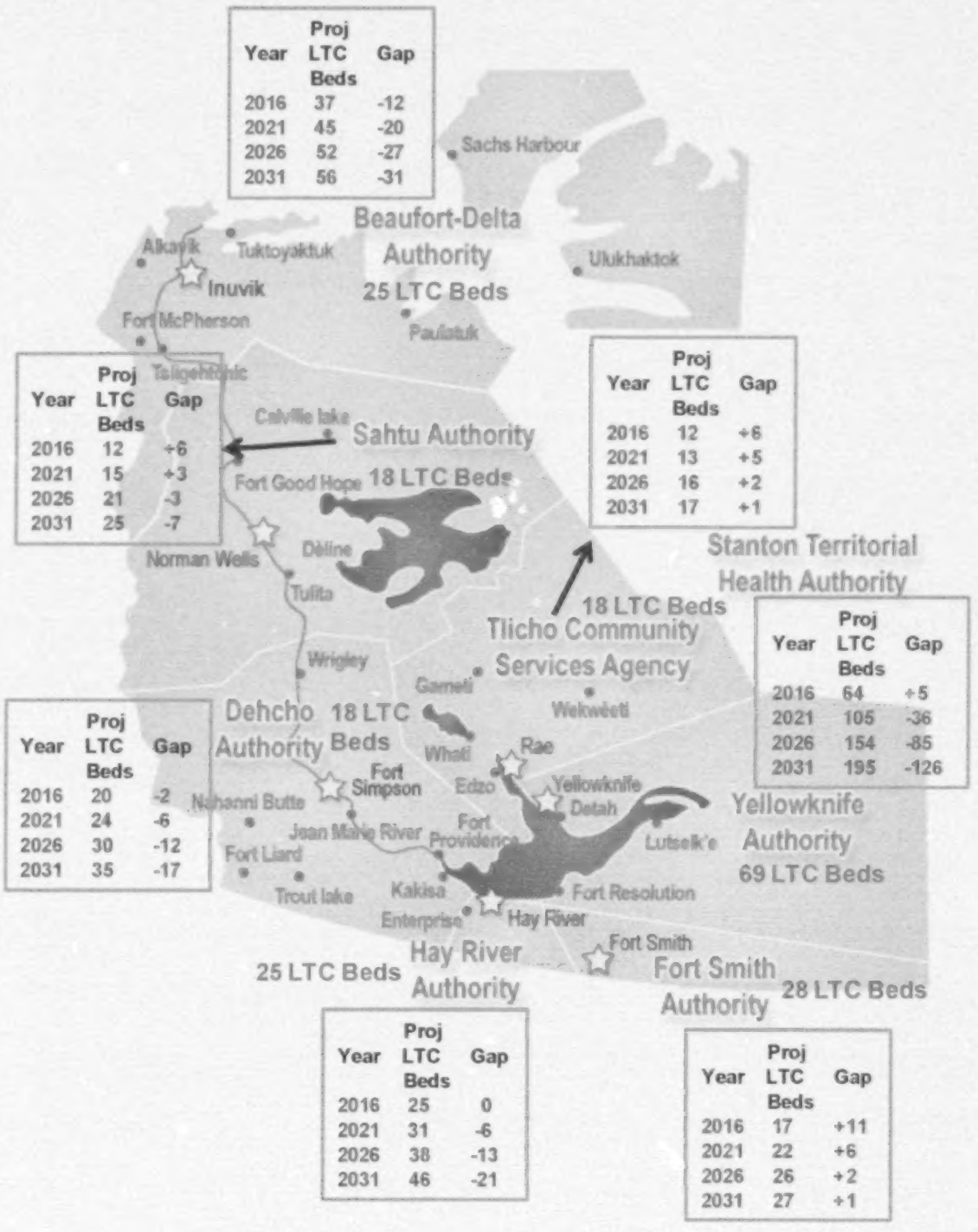
[56] Planning Study: Long Term Care Facilities. PSAV Architects for Government of Northwest Territories. April, 2010.
[57] New Directions for Facility-Based Long-Term Care. Canadian Healthcare Association. 2009.
[58] New Directions for Facility-Based Long-Term Care. Canadian Healthcare Association. 2009.

Table 23: Projected LTC Bed Requirements for each HSSA

LTC Bed Projection Model	2011		2016		2021		2026		2031	
	LTC Beds	Gap	LTC Beds	Gap	LTC Beds	Gap	LTC Beds	Gap	LTC Beds	Gap
Beaufort-Delta - 25 LTC beds available										
1	33	-8	39	-14	50	-25	61	-36	69	-44
2	33	-8	38	-13	47	-22	56	-31	62	-37
3	**33**	**-8**	**37**	**-12**	**45**	**-20**	**52**	**-27**	**56**	**-31**
Dehcho - 18 LTC beds available										
1	15	+3	21	-3	26	-8	33	-15	40	-22
2	**15**	**+3**	**20**	**-2**	**24**	**-6**	**30**	**-12**	**35**	**-17**
3	15	+3	20	-2	23	-5	28	-10	32	-14
Fort Smith - 21 LTC beds in 2011 and 28 beds available 2016 to 2031										
1	16	+5	18	+10	24	+4	30	-2	33	-5
2	16	+5	18	+10	23	+5	27	+1	29	-1
3	**16**	**+5**	**17**	**+11**	**22**	**+6**	**26**	**+3**	**27**	**+1**
Hay River – 25 LTC beds available										
1	21	+4	26	-1	34	-9	44	-19	56	-31
2	21	+4	25	0	32	-7	41	-16	50	-25
3	**21**	**+4**	**25**	**0**	**31**	**-6**	**38**	**-13**	**46**	**-21**
Sahtu – 0 LTC beds in 2011 and 18 LTC beds available 2016 to 2031										
1	12	-12	12	+6	16	+2	22	-4	28	-10
2	**12**	**-12**	**12**	**+6**	**15**	**+3**	**21**	**-3**	**25**	**-7**
3	12	-12	12	+6	15	+3	19	-1	22	-4
Tlicho – 8 LTC beds in 2011 and 18 LTC beds available 2016 to 2031										
1	12	-4	13	+5	14	+4	17	+1	19	-1
2	**12**	**-4**	**12**	**+6**	**13**	**+5**	**16**	**+2**	**17**	**+1**
3	12	-4	12	+6	13	+5	15	+3	15	+3
Yellowknife – 69 LTC beds available (includes 12 beds at Stanton ECU)										
1	44	+25	67	+2	116	-47	181	-112	241	-172
2	44	+25	65	+4	110	-41	165	-96	214	-145
3	**44**	**+25**	**64**	**+5**	**105**	**-36**	**154**	**-85**	**195**	**-126**
NWT Total – 166 LTC beds in 2011 and 191 available 2016 to 2031										
1	153	+13	197	-6	281	-90	388	-197	486	-295
2	153	+13	191	0	265	-74	356	-165	432	-241
3	153	+13	186	+5	253	-62	331	-140	394	-203

Figure 17 contains a map depicting the projected LTC bed requirements and associated gaps based on the recommended projection models for each HSSA. A discussion of the projected LTC bed requirements and projected gaps for each HSSA is provided below.

Figure 17: Map Showing LTC Bed Requirements for each Region



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4.2.2.1 Beaufort-Delta HSSA

There are currently 25 LTC beds available in the BDHSSA which are all currently located in Inuvik. This includes the 3 beds designated for respite care. The number of LTC beds available is expected to remain at 25 throughout the projection period. Based on LTC bed projection model 3, the HSSA already has a deficit of 8 LTC beds. By the year 2031, the HSSA is projected to have a requirement for 56 LTC beds due to the projected growth of 113% for the 70 plus age group. This would result in a projected deficit of 31 LTC beds based on the expected capacity in the HSSA.

4.2.2.2 Dehcho HSSA

There are currently 18 LTC beds available in the DHSSA which are all located in Fort Simpson. This includes the 1 bed designated for respite care. The number of LTC beds available in the HSSA is expected to remain at 18 throughout the projection period. Based on projection model 2, the HSSA currently has a sufficient number of beds to meet current demand based on a surplus of three beds in 2011. However, the HSSA is projected to have a requirement for 20 LTC beds by 2016 resulting in a projected deficit of 2 LTC beds. By the year 2031, the HSSA is projected to have a requirement for 35 LTC beds due to the projected growth of 161% for the 70 plus age group. This would result in a projected deficit of 17 LTC beds based on the expected capacity in the HSSA.

4.2.2.3 Fort Smith HSSA

The FSHSSA is currently funded to operate 28 LTC beds which are all located in Fort Smith. This includes the 2 beds designated for respite care. As previously discussed in Section 3.2, the HSSA operated 21 LTC beds including two respite beds prior to the 2013/2014 fiscal year, with the 7 remaining LTC beds being closed. Assuming that the HSSA will continue to operate 28 LTC beds throughout the projection period, it is projected to have a surplus of LTC beds in 2016 and 2021 and a sufficient number of LTC beds through to the year 2031 based on projection model 3. By the year 2031, the HSSA has a projected requirement for 27 LTC beds, one less than the current capacity of 28.

4.2.2.4 Hay River HSSA

There are currently 25 LTC beds available in the HRHSSA which are all located in Hay River in two different facilities. However, LTC bed capacity in the HSSA going forward is uncertain due to the pending closure of the 10 LTC beds at H.H. Williams. Assuming that the 10 LTC beds eliminated at H.H. Williams are replaced at Woodland Manor, the LTC capacity in the HSSA throughout the projection period would be 25. Based on projection model 3, the HSSA is projected to have a requirement for 25 LTC beds in 2016. By the year 2031, the HSSA is projected to have a requirement for 46 LTC beds due to the projected growth of 166% for the 70 plus age group. This would result in a projected deficit of 21 LTC beds based on an expected capacity of 25 in the HSSA.

4.2.2.5 Sahtu HSSA

There are currently no LTC beds available in the SHSSA. However, there is a new 18 bed facility planned for Norman Wells that includes 16 LTC beds and 2 beds for respite/palliative care. Assuming that this facility is ready for occupation by 2016, the expected capacity for the HSSA would be 18 LTC beds throughout the projection period. Based in projection model 2, the HSSA is projected to have a surplus of 6 beds in 2016 to be operating near full capacity by 2021. By the year 2031, the HSSA is projected to have a requirement for 25 LTC beds due to the projected growth of 131% for the 70 plus age group. This would result in a projected deficit of 7 LTC beds based on the expected capacity of 18 in the HSSA.

4.2.2.6 Tlicho Community Services Agency

There are currently 8 LTC beds available in the TCSA. However, the 8 LTC beds in the Jimmy Erasmus facility will be closed and replaced by a new 18 bed facility in Behchoko that includes 16 LTC beds and 2 beds for respite/palliative care. Assuming that this facility is ready for occupation by 2016, the expected capacity for the TCSA would be 18 LTC beds throughout the projection period. Based on projection

model 2, the TCSA would have sufficient supply throughout the projection period through to the year 2031 with projected LTC bed surpluses throughout the projection period. The new facility is expected to operate at near capacity by 2031. The 18 LTC beds are projected to be sufficient to meet the demand from the projected population growth of 59% in the TCSA.

4.2.2.7 Yellowknife HSSA

There are currently 69 LTC beds available to residents of the YHSSA which are located in three different facilities and managed by 2 different organizations (Avens and Stanton Territorial Health Authority). This includes the 5 beds designated for respite care and the 1 bed designated for palliative care. The number of LTC beds available in the YHSSA is expected to remain at 69 throughout the projection period. Based on LTC projection model 3, the HSSA currently has a surplus of 25 LTC beds. However, by the year 2016, the HSSA is projected to have a requirement for 64 LTC beds and a projected surplus of 5 beds. By the year 2031, the HSSA is projected to have a requirement for 195 LTC beds due to the projected growth of 449% for the 70 plus age group. This would result in a projected deficit of 126 LTC beds based on an expected capacity of 69 in the HSSA.

4.2.2.8 Total Projected Need for NWT

The total projected need for LTC beds in the NWT is shown in Table 24. Based on a LTC bed base of 201, there will be a projected surplus for the territory in 2016 and projected deficits for the remainder of the projection period to 2031. By 2031, the deficit for the territory is projected to be a total of 200 LTC beds.

Table 24: Total Projected Need for LTC Beds in the NWT

HSSA	2011	2016	2021	2026	2031
Beaufort-Delta	33	37	45	52	56
Dehcho	15	20	24	30	35
Fort Smith	16	17	22	26	27
Hay River	21	25	31	38	46
Sahtu	12	12	15	21	25
Tlicho	12	12	13	16	17
Yellowknife	44	64	105	154	195
NWT Total	**153**	**187**	**255**	**337**	**401**
Surplus/Gap	**13**	**14**	**-54**	**-136**	**-200**

Territorial Dementia Beds

Included in the bed based for the Yellowknife HSSA are the 24 beds at Aven Cottages, the Territorial Dementia Facility. These specialized beds are typically occupied by residents who come from communities and other LTC facilities located throughout the NWT, not just Yellowknife.

MNP projected the need for dementia care beds based on TAC assessment data (Table 14). Of 175 clients assessed by the TAC from 2009/10 to 2012/13, 37 (21%) required dementia care. This ratio was applied to the total projected LTC bed requirements for the territory (Table 24) to determine the projected need for dementia care from 2011 to 2031 (Table 25). Based on TAC assessment, the projected need for dementia beds in the NWT in 2011 was 32 resulting in a deficit of 8 beds. By the year 2031, the projected need for dementia beds will increase by 2.6 times to 84 of the 401 LTC beds projected for the territory resulting in a deficit of 60 dementia beds. This is similar to the projections made by the Alzheimer

Society, which projected a 2.3 times increase in the number of Canadians with dementia by the year 2038.[59]

Table 25: Projected Need for Dementia Beds in the NWT

Year	Projected Need for Total LTC Beds in NWT (A)	Projected Need for Dementia Care (A * 0.21)	Gap
2011	153	32	-8
2016	187	39	-15
2021	255	54	-30
2026	337	71	-47
2031	401	84	-60

Extended Care Beds

Similar to dementia beds, extended care beds are specialized and occupied by residents across the NWT. There are currently 12 beds at the ECU including 10 that are designated for extended care and 2 for respite/palliative care.

Although there was no data available as to the exact medical needs of extended care patients, the Continuing Care Level of Services framework does define extended care patients as requiring a level of care of 5 and as persons with complex conditions requiring 24-hour nursing care, support from other health professionals and medical supervision. Using the TAC waitlist data as a proxy, shows that 4% (7 of a total of 175, see Table 21) of applicants assessed by the TAC required a level of care of 5. This ratio was applied to the total projected LTC bed requirements for the territory (Table 24) to determine the projected need for extended care from 2011 to 2031 (Table 26). It is assumed that the total number of extended care beds will remain at 12 throughout the projection period. The projected need for extended care beds in 2011 was 6 resulting in a surplus of 6 beds. By the year 2031, the projected need for extended care beds will be 16, resulting in a deficit of 4 extended care beds.

Table 26: Projected Need for Extended Care Beds in the NWT

Year	Projected Need for Total LTC Beds in NWT (A)	Projected Need for Extended Care (A * 0.04)	Gap
2011	153	6	+6
2016	187	8	+4
2021	255	10	+2
2026	337	14	-2
2031	401	16	-4

[59] Rising Tide: The Impact of Dementia on Canadian Society. Alzheimer Society, 2010.

5.0 Best Practice Research

The following section highlights best practices in other jurisdictions for supporting individuals to stay in their own homes. The research conducted focused on:

- Programs and services that provide independent living supports which are more basic than home care; and
- Restorative approaches to care.

5.1 Independent Living Supports

MNP examined the independent living supports that can help seniors stay in their homes that were outlined in the strategies of three provinces including Alberta, Manitoba and Nova Scotia.

5.1.1 Alberta

The following are key supports noted in the 2013 report by the Chief Medical Officer of Health in Alberta:[60]

- Providing seniors with access to the following programs and services:
    - Affordable and accessible transportation options that allow seniors get where they need to go.
    - Affordable housing options that are free from barriers, low maintenance and located near a range of services, amenities and activities.
    - Supports for household services including maintenance, cleaning and yard work.
    - Home-delivered meals, grocery delivery or cooking services.
    - Property tax deferral.
- Having family members and other informal caregivers provide care and support.
- Providing supports to informal caregivers including peer support, education, financial security, information and resources, financial supports for transportation and accommodation and access to community based support.
- Having age-friendly buildings including stores, community facilities and public buildings.
- Reorienting health and social services to better promote healthy aging through enhancing health promotion and disease prevention and control.
- A team-based approach to community health that involves a variety of health professionals including family physicians, nurses, pharmacists, mental health therapists, rehabilitation therapists optometrists, home care providers, social workers and others.
- Leveraging technological solutions to assist with health and personal care activities such as medication management and mobility assistance throughout the home for going up and down stairs and getting in and out of the bath or bed.
- Providing seniors with assistance to navigate the health and social services system.

[60] Let's Talk about Aging: Aging Well in Alberta. Report by the Chief Medical Officer of Health. Alberta Health, May 2013.

- Providing recreation and leisure activities that are targeted at seniors to keep them active.
- Recognizing the diversity and different needs of older adults by developing programs and public events that are accessible and relevant to everyone and by providing information in different forms, languages and channels to meet different needs and preferences.

5.1.2 Manitoba

The 2012 Manitoba Continuing Care Strategy noted the following key supports:

- Enhancing self/family managed care.
- Providing appropriate supports to family and informal caregivers including in-home and outside the home respite services and caregiver tax credits.
- Improving access to home care services in rural in remote communities by improving travel options for home care staff and using technology such as telehealth.
- Integrating mental health support into the home care process.
- Providing supportive services such as transportation, meals, recreation and household maintenance services.
    - Consider use of partnerships with community agencies to expand or enhance the funding for meal programs, home maintenance needs, transportation and grocery shopping when appropriate.
- Providing an integrated continuum of care that has seamless transition across points of care.
- Have strong partnerships between primary care providers and the home care team.
- Providing affordable assisted living and supportive housing options with appropriate supports.
- Ensuring a sufficient supply of supportive housing in each community.

Manitoba Healthy Living, Seniors and Consumer Affairs has implemented the 'Age-Friendly Manitoba Initiative' to support seniors in leading active, socially engaged, independent lives that contribute to healthy aging.[61] The initiative is led by the Seniors and Health Aging Secretariat to create age-friendly communities that:[62]

- Recognize the diversity among older adults.
- Encourage health and active aging.
- Support the contributions of older adults.
- Promote the participation of older adults in all aspects of the community.
- Engage stakeholders in building age-friendly communities.
- Create accessible and safe environments for older adults.
- Treat people of all ages with respect.

The Minister recognizes age friendly communities with a recognition award for achieving age-friendly milestones. The Manitoba Government has invested more than $2.5 million in age-friendly initiatives through partner organizations and communities to develop and enhance age-friendly programs and services throughout the province.[63]

[61] http://www.gov.mb.ca/shas/agefriendly/index.html.
[62] http://www.gov.mb.ca/shas/agefriendly/initiative.html.
[63] http://news.gov.mb.ca/news/index.html?archive=&item=19578.

5.1.3 Nova Scotia

The Continuing Care Strategy for Nova Scotia noted the following key supports:[64]

- Developing a caregiver strategy that includes caregiver assessment and a menu of supports that offer choice and meet social, economic and health needs.
- Improving how individuals and their families access and move through the continuing care system by creating a directory of services that is available in multiple languages.
- Communicating information about how to access available services to the public.
- Providing transportation to enhance mobility and independence.
- Providing more affordable housing options.
- Expanding home repair and adaptation programs to allow seniors to stay in their home longer.
- Providing an equipment loan program to enhance independence and comfort.
- Expanding access to home oxygen.
- Expanding the self-managed care program to allow individuals to manage and direct the support services provided.
- Expanding respite care options for caregivers.
- Revising policies to reflect diverse needs and ensure equitable access to services.
- Aligning health services to better support individuals as they access and navigate services in homes, communities, hospitals and facilities.

5.2 Restorative Approaches to Care

A restorative approach typically refers to intensive and time-limited inter-professional home care services developed for people with poor physical and/or mental health, to help them learn or re-learn the skills necessary to manage their illness and to maximally participate in everyday activities.[65] Restorative programs include services that maximize an older person's potential within the recovery process. Programs typically provide a comprehensive assessment and time-limited plan of rehabilitation in the client's own home.[66] Restorative programs vary widely in structure but are based on the following common principles:

- Focus on helping clients 'to do' instead of 'doing for' clients;
- Identify expected outcomes; and
- Define maximum duration.

Literature shows that seniors who received restorative home care after an acute illness or hospitalization had a greater likelihood of staying at home, required less service in the long term and had a reduced likelihood of visiting an emergency department than if they received usual home care services.[67]

Restorative approaches to home care can:[68]

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[64] Continuing Care Strategy for Nova Scotia: Shaping the Future of Continuing Care. Nova Scotia Health.
[65] Enabling independence: restorative approaches to home care provision for frail older adults. Ryburn, Wells,& Foreman. Health and Social Care in the Community. 2009.
[66] RFA+ Re-ablement for All Overall Findings Report. Social Work Co-operative, 2010.
[67] Enabling independence: restorative approaches to home care provision for frail older adults. Ryburn, Wells,& Foreman. Health and Social Care in the Community. 2009
[68] Manitoba 2012 Continuing Care Strategy.

- Improve both functional and social status of clients;
- Reduce dependency on home care services; and
- Improve the capacity to cope with the growing demand for home care services.

The continuing care strategies for Manitoba and Nova Scotia both note that they will develop a restorative care program to support their strategies. The Manitoba Strategy focuses on developing a Restorative Home Care Model that includes the use of physiotherapists and occupational therapists to improve a client's functional outcomes.[69] The Nova Scotia Strategy notes developing a restorative care program that will expand restorative care beds and expand home care services to include occupational and physical therapy services to reduce premature and unnecessary admission to LTC and hospitals.[70]

[69] Manitoba 2012 Continuing Care Strategy.
[70] Continuing Care Strategy for Nova Scotia: Shaping the Future of Continuing Care. Nova Scotia Health.

6.0 Conclusions

Based on the principal findings of the review, MNP has drawn conclusions that we believe are consequential to the development of Department's Continuing Care Strategy and MNPs recommendations presented in Section 7.0 of this report.

The following are conclusions regarding health status in the NWT.

1. **The population of the 60 plus age group grew 82.5% from 2001 to 2012.** This was based on data provided by the NWT Bureau of Statistics. This population growth in this age group has increased the need for Continuing Care services.

2. **Elders have a higher incidence of chronic disease and stress and a lower self reported health status.** The number of elders who self-rated their health status as good was lowest amongst all age groups in the NWT. They also reported the highest level of stress and had the highest incidence of diabetes, cancer, high blood pressure, and arthritis, resulting in a greater need for health services. Resources and training will be required to allow Continuing Care staff to provide services that enable elders with these conditions to remain in the community.

3. **Circulatory, respiratory, digestive system, cancers and injuries were the top five conditions that accounted for two-thirds of hospital patients aged 65 and over in the NWT.** This was based on data in the 2013 NWT Hospitalization Report. Resources and training will be required to allow Continuing Care staff to provide services to enable elders with these conditions to remain in the community and reduce hospitalizations.

4. **The population of the 70 plus age group is projected to grow significantly in the NWT by the year 2031.** The greatest growth is projected for the YHSSA, which is projected to see a 449% increase in the population of the 70 plus age group. The population of this age group is also projected to at least double in all other HSSAs with the exception of the TCSA, where growth is projected to be 59%. This projected growth will increase the demand for services along the entire continuum of care in the NWT

The following are general conclusions regarding the delivery of Continuing Care Services in the NWT.

5. **A continuing care framework model was developed in 2008.** Documentation for this model was provided to MNP. This model illustrates the current model for service delivery which includes the three streams of HCC, LTC, and supported living.

6. **The DHHS has developed a framework for levels of service for Continuing Care in the NWT.** Documentation for this model was provided to MNP. This framework identifies the type of care required for individuals assessed at six different levels of care.

7. **The Department is finalizing standards for Continuing Care services in the NWT.** This includes the three program streams as well as services delivered by each program such as respite care, day programming, and palliative care. A draft of the standards developed by the Department was provided to MNP and is awaiting approval.

8. **Aging in place is a goal for Continuing Care services in the NWT.** There is a desire to have residents age in their community and to provide the supports required to accomplish this goal.

6.1 Home and Community Care

The conclusions for HCC in the NWT have been organized into five categories: service delivery, funding, collaboration with NWTHC, respite care and palliative care.

6.1.1 Service Delivery

9. **The delivery of HCC services across the NWT is fragmented and inconsistent.** The services delivered by each HSSA vary and is dependent on the size of each community and the resources that exist. The service provider mix levels (Table 27) and distribution of service hours by activity (Table 6, Section 3.1.1) varied between the HSSAs, consistent with key informant perceptions of inconsistent service delivery between HSSAs. Overall, there were a total of 86.46 FTE HCC working in the NWT in 2012/13. Nursing staff represented 22.0 FTE (24%) of the service providers and HSWs and equivalents represented 51.6 FTE (57%) of the service providers.

Table 27: Summary of Service Provider Mix by HSSA in 2012/13 (FTE Staff)

HSSA	Nursing	HSW[71]	Dietician	Social Work	HCC Coordinator/ Manager	Other[72]	Total
Beaufort-Delta	0.5	15.0	-	1.0	1.0	1.0	18.5
Dehcho	-	7.5	-	-	1.0	1.0	9.5
Fort Smith	3.0	3.5	-	-	-	-	6.5
Hay River	4.0	2.5	1.0	-	-	-	7.5
Sahtu	1.0	7.5	-	-	-	-	8.5
Tlicho	3.5	4.5	-	1.0	2.0	1.5	12.5
Yellowknife	10.0	11.1	1.0	1.0	3.0	2.2	28.3
NWT Total	**22.0**	**51.6**	**2.0**	**3.0**	**7.0**	**5.7**	**91.3**

10. **There are disparities and inequities in the delivery of HCC services between HSSAs.** These were perceived to be due to the historical funding approach for HCC services rather than having a funding approach that is based on need. Key informants also perceived that there were inequities related to the number of HCC nurses providing services for the YHSSA, which has a large population, compared to the other HSSAs with significantly smaller populations.

    Table 28 shows that the ratio of nursing staff, HSWs and other staff per 100 HCC clients is varied in each HSSA, suggesting key informant perceptions of disparities in service delivery may be valid. In particular, there was a perception of service disparities for the YHSSA which is supported by the ratio of nursing staff per 100 HCC clients which is lower than that of FSHSSA, HRHSSA and the TCSA, but larger than that of the BDHSSA, DHSSA and SHSSA. Considering that the population of those aged 60 plus is projected to grow by 156% by 2031 for the YHSSA, significantly more than all other HSSAs, there will be a significant increase in the need for HCC services. This will add to the disparity if the service provider mix in the YHSSA is not adjusted based on need.

[71] Includes Personal Support Workers and Home Maker Positions as well.
[72] Includes Clerical Support, Activity Aide, Regional Activity Coordinator, Clerk Interpreter, Unit Clerk, Fitness Facilitator and Lunch Cook Positions.

Table 28: Ratio of HCC Service Providers per 100 HCC Clients

HSSA	Nursing	HSW	Other	Total
Beaufort-Delta	0.14	4.27	0.85	5.27
Dehcho	0.00	2.34	0.63	2.97
Fort Smith	2.48	2.89	0.00	5.37
Hay River	1.44	0.90	0.36	2.71
Sahtu	0.70	5.24	0.00	5.94
Tlicho	3.54	4.55	4.55	12.63
Yellowknife	1.32	1.46	0.95	3.72
NWT Total	**1.06**	**2.49**	**0.85**	**4.41**

11. **There are no territorial wide standards for the delivery of HCC services in the NWT.** This was perceived to contribute to inconsistent service delivery for HCC across the territory. Many key informants indicated that a set of standards are required for the delivery of HCC services in the NWT that provide a degree of flexibility to account for the unique needs of each HSSA. This includes the development of service limits, especially for HSWs who provide home support services to clients that are in some cases out of the scope of HCC services. The Department is currently in the process of developing a draft set of standards for Continuing Care that includes HCC.

12. **There is no consistent admissions process for HCC services in the NWT.** There was no documented approach for admissions into HCC for the NWT. A number of key informants also noted that there is no consistent approach for admission into the home care program of the different HSSAs. The YHSSA is using a system that admits clients based on priority and through a single point of entry which was perceived to be working well. However, admission into HCC in the other HSSAs was perceived to be based on demand (those who ask for services) rather than based on need.

    The Inter-RAI Home Care (RAI-HC) tool was identified by many as an improved assessment tool for home care admissions that could allow for better data collection. The tool could be used for admissions into home care as well as admissions into LTC allowing for better continuity of care across the continuum. . The Department has established an InterRAI Steering Committee to develop a business case and implementation plan for Inter-RAI Home Care.

13. **The acuity of HCC clients is perceived to be increasing and is expected to increase in the future.** There was a perception by key informants that there was an increase in the acuity of HCC clients due to early discharges from acute care centres as well as a desire on the part of community members to remain in the home longer with more complex conditions.

    An analysis of Health Suite data showed that the number of hours spent on acute post hospital care was significant in some HSSAs (25% for the YHSSA and 15% for the HRHSSA) but was reported to be very low in the other HSSAs. Overall, the large majority of care was provided to chronic continuous clients in all HSSAs. Nursing care represented a small portion of the care provided in some HSSAs (DHSSA, SHSSA, and TCSA) and a more significant portion of care for the larger regional centres with acute care facilities (BDHSSA, FSHSSA, HRHSSA, and YHSSA). This is consistent with the service provider mixes listed in Table 34 above, except for the BDHSSA which only has a 0.5 FTE Nurse listed. Home making, home management and personal care also made up a large portion of the services provided in each jurisdiction and represented the majority of service delivery for most HSSAs with the exception of HRHSSA and YHSSA. This suggests that the focus for HCC services in most HSSAs has been for the treatment of lower acuity conditions and for providing personal support for clients in the home.

14. **Increasing support from expert resources would enhance delivery of HCC services in the NWT.** Other Canadian jurisdictions such as Manitoba have identified a need to provide supports from expert resources to enhance continuing care services including home care. The continuing care strategy for Manitoba includes investing in interdisciplinary teams of psychology, geriatric and geriatric mental health professionals to support dementia care in communities as well as using rehab professionals to support a restorative approach to home care.

    A need for more expert resources was identified to provide more complex care, service higher acuity clients and enhance the delivery of HCC services in the NWT. Needs were identified for geriatrics, geriatric psychiatry, dietician services and rehabilitation services.

15. **Expanding the hours of operation for HCC would enhance services in many HSSAs.** Jurisdictions across Canada are expanding hours of health service delivery to better meet the needs of their constituents and provide better access to services. Alberta, for example has expanded home care hours to enhance service delivery.[73] A number of HSSAs noted that there is a need for more resources in order to expand services and hours of operation of HCC. Some HSSAs indicated that they already provide extended hours for evening tuck-in services as well as weekend services.

16. **The management and coordination of HCC is not consistent between HSSAs as well as within HSSAs.** This was identified as a challenge by representatives from the Department as well as the HSSAs. Oversight of HCC staff varies by HSSA. In some HSSAs and communities, oversight is provided coordinators and nurses involved in the delivery of HCC services while in others it is provided by nursing staff whose primary responsibility is not HCC which creates challenges. In particular, the provision of nursing oversight for client assessments and the provision of services by HSWs were sighted as areas of concern.

17. **The demand for HCC services is expected to increase.** The increase will be driven by the projected growth of the 60 plus age group in the NWT as well as a philosophy for Continuing Care services that allows NWT residents age in their community. This increase will impact the service provider mixes and the requirements for HCC services going into the future.

18. **A restorative approach to care can reduce dependency on HCC services.** Literature shows that seniors who received restorative home care after an acute illness or hospitalization had a greater likelihood of staying at home, required less service in the long term and had a reduced likelihood of visiting an emergency department than if they received usual home care services. Manitoba and Nova Scotia are incorporating a restorative approach to care to support their Continuing Care Strategies. A need for a restorative approach to HCC services in the NWT was identified by some key informants.

6.1.2 Funding and Reporting

19. **There are two sources of funding for HCC in the NWT.** Currently, HCC services are funded by Department core funding as well as FNIHCC funding through FNIHB. The Department core funding is allocated based on historical levels rather than need. In 2012/2013, there was a total budget of approximately $9.8 million of which approximately $6.1 million (62%) was core HCC funding and $3.7 million (38%) was FNIHCC funding. The Department currently has a five year agreement with FNIHB for the FNIHCC funding that expires March 31, 2018. There was concern regarding the degree to which the delivery of HCC services is dependent on FNIHCC funding because if this funding were to discontinue, there would be challenges with maintaining the current level of services.

[73] http://www.albertahealthservices.ca/6629.asp. Accessed August 15, 2013.

The level of risk associated with the current funding model for HCC services is low for the Department, because the agreement with FNIHB expires in 5 years, which controls this risk. However the impact of this risk is high, because the FNIHCC funding represents a significant portion of overall HCC funding and a loss of this funding would inhibit the ability to sustain a level of HCC services that allows elders to age in their community. As the expiry date for the current agreement approaches, the level of risk related to the FNIHCC funding increases and could require mitigation by the GNWT.

The degree to which the HSSAs were reliant on FNIHCC funding for the delivery of HCC services varied. Approximately 51% of the HCC budget for the BDHSSA was FNIHCC funding compared to the HRHSSA where FNIHCC funding represented 29% of the HCC budget. The level of risk associated with FNIHCC funding for each HSSA is significantly higher, as each HSSA must submit annual proposals to secure this funding. The impact of this risk varies by HSSA based on the degree that they are reliant on FNIHCC funding. However, considering that FNIHCC funding represents a significant portion of HCC funding in each HSSA, the impact of this risk is also considered high.

20. **The spending for HCC services exceeded total budget.** Based on the budget numbers provided by the Department, there was an overall deficit from the delivery of HCC in the NWT. The deficit for 2010/11 was $428,390 and the deficit for 2011/12 was $65,300. The observed deficits were driven primarily by overspending in FNIHCC funding for the BDHSSA due to no FNIHCC budget being provided in 2010/11 and 2011/12.

    a. A Department representative reported that overspending did not occur for HCC and that the numbers provided by the Department do not include carryover funding from unspent funds from previous years.

21. **The application requirements for FNIHCC funding do not appear to be consistent.** The content describing the background and project being funded for each HSSA in the contribution agreements is not provided in a consistent format.

22. **There are limited reporting requirements for HCC funding.** There are no requirements to report on HCC activity and outcomes for the core HCC funding and limited reporting requirements for the FNIHCC funding. There was some concern expressed by Department regarding the lack of reporting requirements. The collection of data for reporting was also noted to be a challenge. Data entry into Health Suite was noted to be inconsistent and a more reliable system for data collection is required.

6.1.3 Collaboration with NWT Housing Corporation

23. **There are 339 independent living units in the NWT targeted at elders and persons with disabilities.** Although these units existed, there was a perception that greater supports were required for these individuals. The NWTHC is currently developing 32 additional independent living units in four facilities for elders that include space for the provision of home care services. There was another six facilities identified in the NWT that are similar to those being planned.

24. **Independent living with HCC supports is an important component of Continuing Care in the NWT and must be included in future planning.** Independent living with HCC supports is critical to an aging in place approach, as it will allow elders to remain in their community longer. Manitoba Health found that supported living has assisted elders to experience an improved quality of life and is looking to continue and expand housing options in its most recent Continuing Care strategy.[74] A need to have more independent housing units targeted at elders and persons with disabilities as well as a need for increased supports for those living in independent housing was identified through

[74] 2012 Continuing Care Strategy. Manitoba Health.

consultations with key informants. It should be noted that the number of independent housing units with supports required was not available for analysis. This will require greater collaboration between the Department and the NWTHC, as both entities have an important role to play in the provision of independent living with HCC support.

6.1.4 Respite Care

An evaluation of respite services was recently completed by the Department in April 2013. The following conclusions reflect the findings from that evaluation as well as the feedback provided through consultations with key informants.

25. **There are currently 14 beds available for respite care.** Currently, there is at least one respite bed available in each HSSA except the SHSSA. However, with the development of the new LTC facility in Norman Wells, there will be two beds designated for respite/palliative care in the SHSSA. Looking forward, the total number of respite beds in the NWT is expected to increase to 18 beds. Some of the key informants who were consulted perceived that there was a need for more respite beds.

26. **There are options for respite care in addition to in-facility care in some HSSAs.** These include in-home respite services through HCC, services provided by NGOs, and day programs.

27. **Respite care is a relevant service in the NWT.** This was a key finding in the 2013 evaluation report for respite services and was consistent with key informant feedback from this project. The 2013 evaluation found that when respite care is available and accessible, it is beneficial to both the client and the family caregiver.

28. **The needs for respite services are not being met in the NWT.** This was another key finding from the 2013 evaluation report for respite services and was also consistent with key informant feedback from this project.

29. **The delivery of respite services varies by HSSA.** This was a key finding of the 2013 evaluation report for respite services. The evaluation found there to be inconsistent eligibility criteria, inconsistent standards for assessing respite patient and caregiver needs, and variability in the availability of services.

30. **The utilization of respite beds varied across the territory.** The occupancy rates of respite beds in some facilities were high while at other facilities they were not. It was also found that in some instances, respite beds were used inappropriately for acute care purposes or to keep those awaiting placement into a LTC bed until a bed becomes available. This was perceived by some to be dangerous as it ties up resources that could be used by others who need them.

31. **The costs for in-facility respite care are not covered in the NWT.** This includes costs associated with travel and accommodation (if required) for clients and family as well as facility costs/fees.

32. **The Department has developed a business case for a Territorial Flexible Respite Model.** The business case documents a strategy for respite care in the NWT including the roles, responsibilities and reporting; staffing requirements; financial overview; and potential benefits and risks of the new model.

6.1.5 Palliative Care

The following are conclusions regarding palliative care services in the NWT.

33. **The NWT is developing an NWT Palliative Care Framework and a logic model for the territory.** Documentation for this model was provided to MNP. This logic model is based on the Palliative and

End of Life Care logic model from the Canadian Partnership Against Cancer. The logic model outlines the short term, medium term and long term outcomes for palliative care in the territory as well as the activities required to achieve those outcomes.

34. **Presently, the delivery of palliative care services across the NWT varies based on the resources available to provide the services.** The majority of palliative care appears to be delivered in-home; however it is also delivered in LTC facilities and acute care settings. There is only one LTC bed designated for palliative care in the NWT, and more being developed in the new facilities in Behchoko and Norman Wells. Some HSSAs noted that they do provide palliative care in their LTC facilities when requested, but they do not have a private space where families can go on their own.

35. **The needs for palliative care were perceived to being met in some HSSAs.** However, this was not perceived to be the case in all HSSAs. Overall, the delivery of palliative care services was perceived to be improving, especially the delivery of in-home palliative care services in communities outside of Yellowknife. There was no data available to validate the perceptions of key informants.

36. **There are no consistent standards and clinical guidelines in the NWT for palliative care.** There are currently no territorial standards or guidelines documented for the delivery of palliative care. Some HSSAs had developed standards and guidelines based on the Victoria Hospice, while other HSSAs reportedly delivered palliative care the best they could on an ad-hoc basis.

37. **Appropriate training is required to enhance the provision of palliative care.** Literature shows that palliative care is interdisciplinary and it is essential that education and training is available for all disciplines including home care workers, volunteers and family caregivers.[75] Some HSSAs had provided palliative care training to staff while some others noted that they had staff with experience with palliative care. Training was thought to be beneficial to staff and families so that they could understand their role in providing palliative care.

38. **The provision of palliative care was perceived to be straining resources in some communities.** Many key informants noted that staff went out of their way to provide palliative care in many HSSAs. However this has created challenges as it resulted in overtime hours and was felt to stretch the resources available for the provision of other health services

6.2 Long-Term Care

The conclusions for LTC have been organized into four categories: LTC bed number and utilization; the TAC; LTC service delivery; and LTC funding.

6.2.1 LTC Bed Number and Utilization

39. **The number of LTC beds in the NWT was sufficient to meet demand in 2011; however the location of LTC beds did not meet the requirements of each HSSA.** Based on the number of people aged 70 plus in the NWT in 2011, the 166 LTC beds available was enough to meet the demand for LTC services in 2011 based on a bed ratio of 110/1000 population aged 70 plus. However, as seen in Table 29 below, the distribution of beds in each HSSA did not meet the demand for LTC services based on this ratio. Based on the 100/1000 ratio, there was a surplus of LTC beds in the Dehcho, Fort Smith, Hay River and Yellowknife HSSAs and a deficit in the Beaufort-Delta, Sahtu and Tlicho HSSAs.

[75] Raising the Bar: A Roadmap for the Future of Palliative Care in Canada, The Honourable Sharon Carstairs, P.C., The Senate of Canada, June 2010.

Table 29: LTC Bed Demand in 2011 by HSSA

HSSA	LTC Beds in 2011	70 + Population	Beds Required based on 110/1000 Ratio	Gap
Beaufort-Delta	25	296	33	-8
Dehcho	18	139	15	+3
Fort Smith	21	149	16	+5
Hay River	25	192	21	+4
Sahtu	0	109	12	-12
Tlicho	8	109	12	-4
Yellowknife	69	399	44	+25
NWT Total	**166**	**1,393**	**153**	**+13**

40. **There are currently 173 LTC beds funded for operation in the NWT.** This is based on documentation provided to MNP by the Department.

41. **There has been high utilization of LTC beds in the NWT.** The average occupancy of LTC beds in the NWT was 97.1% in 2011/12 and 96% in 2012/13. Eight of the nine LTC facilities had occupancy rates over 95% in 2011/12 and seven of the nine facilities had occupancy rates over 95% in 2012/13.

42. **The average age of LTC bed residents was 77 or older in most LTC facilities.** This was true for all facilities except the Stanton ECU, where the average age of residents was 65 in 2011/12 and 67 in 2012/13. This demonstrates that the majority of LTC residents are over the age of 70 in the NWT.

43. **The average level of care of LTC residents is consistent with the NWT Continuing Care Levels of Service Framework.** The current levels of service framework for the NWT indicates that individuals assessed as requiring level 3 and level 4 care are appropriate for LTC or dementia care. The average level of care of the residents in each LTC facility was at least 3.0 or higher in 2011/12 and 2012/13.

44. **The number of LTC beds by the year 2016 is expected to be 201.** This includes the 18 new LTC beds that are being developed in Behchoko as well as the 18 new LTC beds being developed in Norman Wells. This also accounts for the closure of 8 LTC beds at Jimmy Erasmus in Behchoko and the replacement of the 10 LTC beds at H.H. Williams at Woodland Manor in Hay River.

45. **The demand for LTC beds is projected to continue growing through to the year 2031.** This will be driven by the projected growth of the 70 plus population in the NWT and will result in a shortage of 54 LTC beds overall in the territory by the year 2021 and takes into account the new beds to be developed in Behchoko and Norman Wells. By the year 2031, there will be a requirement for an additional 200 LTC beds in the NWT (see Section 4.2 above). Table 30 summarizes the projected LTC bed surplus and deficit for each HSSA. The LTC bed projection models used takes into account a reduction in the use of LTC beds consistent with an aging in place approach. A detailed discussion of the LTC bed requirements for each HSSA is provided in Section 4.2 above.

Table 30: Projected LTC bed surplus/deficit in each HSSA

HSSA	2016 Gap/Surplus	2021 Gap/Surplus	2026 Gap/Surplus	2031 Gap/Surplus
Beaufort-Delta	-12	-20	-27	-31
Dehcho	-2	-6	-12	-17
Fort Smith	+11	+6	+2	+1
Hay River	0	-6	-13	-21
Sahtu	+6	+3	-3	-7
Tlicho	+6	+5	+2	+1
Yellowknife	+5	-36	-85	-126
NWT Total	**14**	**-54**	**-136**	**-200**

46. **The demand for dementia care beds in the NWT is expected to grow.** There is a projected shortage of 15 dementia care beds for the territory by the year 2016 (see Section 4.2.2.8 above). By the year 2031, there is a projected shortage of 60 dementia care beds.

47. **The development of LTC beds in Behchoko and Norman Wells is appropriate when considering long-term requirements.** There was some concern expressed regarding the development of the new LTC facilities in Behchoko and Norman Wells and whether the new beds will be utilized or not. Tables 29 and 30 above show that there is a requirement for additional LTC beds in Behchoko (TCSA) and Norman Wells (SHSSA). When looking at the projected LTC bed requirements for 2016, it appears that the 18 LTC beds being developed in each HSSA is more than what is required. However, in the long-term, it is projected that the beds in Norman Wells will be fully utilized and that the beds in Behchoko will be 89% occupied by the year 2026.

6.2.2 Territorial Admissions Committee

48. **The TAC has improved the process for placing residents into LTC beds in the NWT.** The Department provided MNP with an orientation binder for the TAC that documented policy, the application process and forms and the priority screening tool used for assessing applications. Key informants noted that the process for placing residents into LTC improved with the TAC because it used a much more transparent and formalized process for placing residents into LTC beds than was previously used when each HSSA had responsibility for LTC placements.

49. **A standard assessment tool is not being used for making placements into LTC.** The current CCAP assessment package is not a standard package used for assessments by other Canadian jurisdictions. Although the current CCAP assessment package is comprehensive, it is cumbersome and time consuming to complete, time consuming to review for TAC members, and was considered to lack credibility in regards to evidence-based decision support. The Inter-RAI Home Care tool was suggested as an improved assessment tool for making placements into LTC that is being used in most Canadian jurisdictions. Inter-RAI has the capacity to provide data about HCC and LTC populations that can assist with planning.

50. **The average wait time for the placement residents since the establishment of the TAC was 74 days.** From October 2009 to March 2013 the TAC placed 164 people into LTC or extended care beds in the NWT with an average wait time of 74 days. As of April 18, 2013, there were 13 people awaiting placement into LTC or extended care beds.

51. **The average assessed level of care of applicants placed into LTC beds by the TAC is consistent with the NWT Continuing Care Levels of Service Framework.** The average assessed level of care of the 175 applicants assessed by the TAC from October 2009 to March 2013 was 3.66. All applicants placed into LTC or extended care beds were assessed as requiring level of care of 3, 4 or 5.

52. **The majority of assessments by the TAC were for LTC or dementia care.** Approximately 168 (96%) of the 175 assessments by the TAC were for LTC or dementia care. Only 7 (4%) of the assessments were for extended care.

6.2.3 LTC Service Delivery

53. **Consistent up-to-date standards for the delivery of LTC services do not currently exist.** MNP was provided with a copy of the standards developed in 2000 and notes that they have not been updated since their original publication date. Key informants indicated to MNP that due to the lack of current standards a number of facilities had developed and implemented their own, resulting in inconsistency. Although MNP did not validate whether these facility specific standards existed, we believe that these perceptions are valid. The Department is in the process of responding to this need and MNP was provided with a draft version of new standards for the delivery of LTC.

54. **All LTC facilities are not currently accredited.** MNP validated that all but two of the LTC facilities operating in the NWT are accredited.

55. **The Department uses a standard of 3.6 hours of direct care per resident for service delivery for most facilities.** This standard has been applied to all facilities except the Stanton ECU and Aven Cottages (the Territorial Dementia Facility). This standard is consistent with other jurisdictions. As of 2013/14, there are no facilities staffed below this standard.

56. **The Department is using a ratio of 20% Nursing staff and 80% RCA for staffing LTC facilities.** This is lower than some other jurisdictions such as New Brunswick that uses a mix of 20% RN, 40% LPN and 40% care aide staff.[76] The NWT developed this ratio based on research of other jurisdictions and an in-depth risk analysis that substantiated this standard provides for an adequate quality of care and minimized potential for risk. Currently, most facilities are staffed with a ratio of nurses/RCAs that is higher than the 20/80 standard with an average ratio of 37% nursing and 63% RCA for the territory. Only Aven Manor is operating at a ratio of lower than 20/80. Staffing adjustments will be required at most LTC facilities to achieve the 20/80 ratio.

57. **There is a desire to have more culturally appropriate service delivery in LTC facilities.** This includes meal selections and programming that is more aligned with the traditions of the Elders residing in the different communities. MNP was unable to validate the degree to which LTC facilities in the NWT are currently providing culturally appropriate services.

6.2.4 LTC Funding and Reporting

58. **There is an overall deficit from operations for the delivery of LTC in the NWT.** The deficit in 2010/11 was approximately $1.1 million and in 2011/12 was approximately $950,000. Four of the facilities in the territory operated with a deficit in 2010/11 as well as 2011/12 which were all driven by staffing costs. Facilities operating at a deficit in both fiscal years were Jimmy Erasmus, Fort Simpson and the Northern Lights Special Care Home.

59. **LTC facility spending is increasing.** Overall, spending increased by 10% from 2010/11 to 2011/12.

60. **Data collection and reporting is challenging.** Although there was data available on LTC utilization, the data provided to MNP for some LTC facilities was incomplete for the 2012/13 fiscal year.

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[76] New Directions for Facility-Based Long-Term Care. Canadian Healthcare Association. 2009.

6.3 Extended Care

The following are conclusions regarding extended care services in the NWT.

61. **All extended care services are provided at the Stanton ECU.** Key informants indicated that extended care services needed to be located in Yellowknife close to a tertiary care centre so that medically complex clients have access to specialized services. Stanton is the only tertiary care centre in the NWT, which is why all of the beds are currently located there.

62. **The needs for extended care appear to being met.** The average occupancy of the ECU at Stanton was 60% in 2010/11, 91% in 2011/12 and 76% in 2012/13. It is unclear as to whether there is limited demand for extended care services in the NWT or if there is a reluctance to use the ECU on the part of individuals requiring these services given the travel required by many outside of Yellowknife to access extended care.

63. **The average level of care of patients occupying beds and being placed into the ECU is 4.3.** The average level of care of patients in the ECU was 4.0 in 2011/12 and 4.5 in 2011/12, lower than the level of care of 5 that is recommended for extended care in the framework. The average level of care of those placed into extended care by the TAC was 4.3. It was noted that clients with high level 4 care needs are sometimes placed into extended care when there is no capacity in other LTC facilities and they cannot be managed in the community.

64. **The average age of patients in the ECU is lower than that of LTC facilities.** The average age of patients in the ECU was approximately 10 years less than that of residents occupying LTC beds. Clients are placed into extended care based on need and not on age.

65. **There ratio of nurses providing care to extended care patients is higher than that of other LTC facilities.** The ratio of nurses to aides in the extended care unit was 85% nursing (42.5% RN and 42.5% LPN) and 15% aide staff. This is nearly the reverse of the ratio for LTC facilities and is reflective of the complex needs that are to be treated by the ECU.

66. **The redevelopment of Stanton provides an opportunity to determine the most appropriate location for ECU beds.** This was noted by some key informants who thought that alternative sites should be considered and explored for these beds.

7.0 Recommendations

The recommendations developed for a new Continuing Care strategy in the NWT are aligned with an aging in the community approach to care, which is a goal of the GNWT as well as an expectation of NWT residents. The achievement of this goal will require change to the approach for delivering services in each stream of Continuing Care as well as significant investments in health resources and infrastructure, given the significant population growth projected for the 70 plus age group in the NWT.

Figure 18 summarizes the current state of the delivery of Continuing Care services in the NWT and provides a framework for recommendations for the future delivery of Continuing Care services in the territory. On the pages that follow, MNP details the recommendations towards a future strategy for the delivery of Continuing Care services for the next 10 years.

Figure 18: Framework for Recommendations to Continuing Care Services in the NWT

Current State

Home and Community Care

- Inconsistent service delivery and disparities between HSSAs.
- No consistent service delivery standards or approach to admissions.
- Limited accountability and reporting.
- Focus is on providing home support services (in most HSSAs). Some HSSAs treat higher acute clients.
- Dependent on funding external to Department core funding.
- Inconsistent management.
- Limited supports to those in independent housing units.
- Perceived shortage of independent living units targeted at seniors and persons with disabilities in many communities.
- Limited coordination between Department and NWTHC to provide independent living with HCC supports.

Long-Term Care and Extended Care

- Operating at full capacity to meet demand in most HSSAs. Shortage of beds in some HSSAs.
- Territorial approach to LTC bed placements which is consistent and standardized. Improved assessment tool required.
- Reliance on LTC due to limited supports in community.
- Inconsistent standards for service delivery.
- Reporting exists, but improvement required.

Complimentary Services (Respite, Adult Day and Palliative Care)

- Inconsistent service delivery and standards (respite and palliative).
- Needs not being met in all HSSAs.
- Not fully utilized (respite).
- Limited resources for service provision (respite and palliative).
- Inconsistent data collection (respite and palliative).
- Inappropriate utilization (respite).

Future Strategy Recommendations

Home and Community Care

- Increase focus and ability to treat higher acute conditions for seniors in the home and the community.
- Define scope of services for home support workers.
- Implement a consistent approach for admission into home care in the NWT.
- Consistent approach for case management.
- Appropriate management of HCC staff.
- Increase HCC support to seniors and persons with disabilities in independent housing units.
- Determine the need for independent housing with HCC supports for seniors and persons with disabilities in the NWT.
- Improve collaborations between the Department and NWTHC.

Long-Term Care and Extended Care

- Ensure sufficient supply of LTC beds and resources in each HSSA to meet projected demand for services.
- Reduce focus on institutional care and increase focus on treating seniors in the community longer.
- Implement an improved admissions tool for the TAC.
- Improved communication of waitlists by TAC.

Complimentary Services (Respite, Adult Day and Palliative Care)

- Ensure sufficient awareness and appropriate utilization of complimentary services.
- Ensure proper skill sets and training for the provision of complimentary services.
- Continue implementation of planning for palliative care and respite care.
- Determine need for all complimentary services.

Consistent standards and guidelines, culturally appropriate care, admissions and funding based on need, improved accountability and reporting, and improved continuity of care between Continuing Care streams that enables seniors to age in the community longer.

Considerations for Strategy Development

The challenge associated with implementing a Continuing Care strategy aligned with an aging in the community approach to care is finding the right balance between HCC, SL and LTC care. There is a growing body of literature indicating that home-based care can improve quality of life and can often be a cost effective substitute for LTC and acute care.[77] It has been found that these savings are greater at the lower levels of care. One study found that the costs for the provision of home care to lower level of care clients were about 40% of the costs of LTC.[78] Another study from the Canadian Health Service Research Foundation found that the implementation of home care as an appropriate and less expensive cost alternative for acute care and LTC has not been totally successful because home care has evolved to be more acute care focused.[79]

The most appropriate place for individuals isn't always in the home. Quality health care is dependent on accessing the right care in the right place at the right time. It is important to keep in mind that there is an important role for acute care and LTC services when individuals have high care needs or are very ill. If the care intensity becomes extensive, as expressed in the number of hours of care, the number of service providers, or necessary equipment, home care expenditures may become more costly than facility-based LTC.[80]

7.1 Recommendations for Entire Continuum of Care

The following recommendations for the delivery of Continuing Care in the NWT cut across the entire Continuum of Care. These recommendations have been developed to improve the consistency of service delivery within and between the three Continuing Care streams as well as for complimentary services.

7.1.1 Complete Development and Implement NWT Continue Care Standards Manual

The Department, in collaboration with the HSSAs, has developed a draft set of standards for Continuing Care services in the NWT (Conclusion 7). The Continuing Care Standards set out the Minister's expectations for care and service delivery for each Continuing Care stream as well as for complimentary services such as palliative care, respite care and adult day programming. The new standards also include expectations related to the provision of culturally appropriate care (Conclusion 57).

It is recommended that the Department continue with the development of these standards and complete the approval of these standards so that they can be put into practice as soon as possible. Inconsistent service delivery (Conclusions 9, 10, 29, 30 and 34) and standards (Conclusions 11, 29, 36, 53 and 54) was a common issue identified throughout the study for the entire continuum of care, and the implementation of the NWT Continuing Care Standards would be a good step towards improving consistent service delivery throughout the territory. It is also recommended that once approved, the Continuing Care Standards be reviewed and updated and a regular basis to ensure that they are up to date. The current draft states that, the standards should be updated every three years or as directed by the Minister which must be adhered to.

[77] Manitoba 2012 Continuing Care Strategy. Manitoba Health.
[78] Final Report of the National Evaluation of the Cost-Effectiveness of Home Care. Hollander and Chapell. August 2002.
[79] Better with Age: Health Systems Planning for the Aging Population. Canadian Health Service Research Foundation. 2011
[80] Manitoba 2012 Continuing Care Strategy. Manitoba Health.

7.1.2 Continue using the Continuing Care Levels of Service Framework

The Department has established a framework for Continuing Care Levels of Service (Conclusion 6). It is recommended that the Department continue using this framework as it provides a basis for consistency in determining the living arrangements and type of care required for different defined levels of care. It is also recommended that the framework be reviewed and updated every two to three years to ensure that the defined levels of care continue to be aligned with the overall strategic direction for Continuing Care in the NWT.

7.1.3 Proceed with Development of a Business Case and Integration Plan for Inter-RAI Home Care

The CCAP is currently being used as the standard assessment tool to support decisions related to client services across the continuum of care (Conclusions 12 and 49). However, the tool was noted to be cumbersome to complete and to lack credibility regarding evidence based decision support. Primary and Continuing Care providers in the Northwest Territories require access to an electronic assessment tool that is standardized and evidence based to support clinical decisions regarding NWT resident's eligibility for services, care planning, case management, and reporting within HCC and LTC service areas.

It is recommended that the Department proceed with the development of a business case and implementation plan for Inter-RAI Home Care for the Continuing Care service area. Inter-RAI Home Care is a standardized electronic tool that will improve consistency for clinical assessments and the management of clients along the continuum of care in the NWT. The system is being used as a standard tool for home care decisions in many Canadian jurisdictions. Some of the noted benefits of the system include:[81]

- It is evidence based standardized clinical assessment tool designed to identify clients at risk of adverse outcomes across care setting.
- It provides real time feedback on client risks and needs for care planning.
- It provides comparable data in all home care service recipients.
- It supports planning for resources to provide services to diverse home care populations.

The Inter-RAI Home Care system could improve the continuity of care across the entire continuum of care and could be used for admissions into HCC, used by the TAC for LTC placements, and used for making decisions related to palliative care and respite care. The system could also ensure that care is being provided based on client need rather than demand.

The implementation of Inter-RAI will require buy in from the management and staff from all HSSAs in the NWT. Therefore, it is also recommended that the implementation plan for Inter-RAI have a strong change management and training component, to ensure the effective implementation of the system.

7.1.4 Determine Performance Measurement Requirements for Continuing Care

In order to support ongoing decision making for Continue Care services in the NWT, it is recommended that the Department's Continuing Care Service area in collaboration with HSSAs develop a performance measurement plan for Continuing Care services in the NWT. The Department was able to provide data and statistics for some aspects of HCC and LTC, but the data was noted to be dated and incomplete, which impacts the ability to make decisions (Conclusions 22, 35, and 60).

The performance measurement plan should include metrics that are meaningful and informative for decision making as well as feasible to measure. In order to be feasible, there must be reliable and timely

[81] Inter-RAI Home Care Project Justification. Provided by the Department.

data available to inform the measure as well as an ability to analyze and report the metric. It is recommended that the Department develop the performance measurement plan in consultation with the HSSAs in order to determine which metrics are of value for decision making, the availability of and capacity to collect data, and to improve buy-in for compliance with performance measurement. The Inter-RAI system recommended in Section 7.1.3 could help improve data collection, however, there will still be a requirement for the collection of reliable activity data for HCC, LTC, extended care and complimentary services (palliative care, respite care and adult day services).

Appendix B provides a description of best practices and critical success factors as well as a sample performance measurement framework from the Canadian Institute for Health Information (CIHI) that can be used as a guideline by the Department for the development of a performance measurement strategy for Continuing Care services in the NWT.

7.1.5 Ensure Funding and Service Delivery are based on Need

It was noted by a number of key informants that the core funding by the Department, which includes funding for a large portion of Continuing Care services, is allocated based on historical funding rather than based on need (Conclusions 10 and 19). There is justification to fund Continuing Care services based on actual need to ensure that residents have fair and equitable access to services. However, in order to fund services in this manner, service delivery must also be based on need (Conclusions 12 and 49). There must also be data available that allows the Department to know what the need is in every HSSA.

Recommendations 7.1.3 and 7.1.4 should help ensure that services are being assessed and provided based on need; however, there will also need to be a culture shift at the level of the service providers to ensure that they are providing services to those who require them rather than those who ask for them with the strongest voice. It is recommended that the Department continue to allocate its core funding for Continuing Care services as is until it has the ability to determine the needs for Continuing Care services in each HSSA. Once the Department can determine those needs in a reliable and accurate manner, it is recommended that the Department allocate funding based on need.

7.1.6 Conduct a Detailed Financial Review of Continuing Care Costs

Based on the scope and data available for this study, a detailed analysis regarding the financial cost implications of an aging in the community approach to Continuing Care services could not be conducted (see limitations noted in Section 2.1). It is recommended that the Department conduct a detailed financial review of Continuing Care costs. Although cost is only one consideration in the approach to delivering Continuing Care services, it should be included as a criterion to inform decision making.

This review should include a detailed analysis of the costs associated with providing care to clients at different levels of care in a HCC setting, independent living with HCC support setting, and a LTC setting. The review should also include an analysis of the cost implications of implementing an aging in the community approach to care which entails expanding HCC services to reduce the requirement for LTC beds as well as determine the costs to address the LTC bed requirements identified in recommendation 7.3.1 below.

The review will enable the Department to make comparisons of the costs involved in delivering care in each Continue Care stream and assist with decisions related to the cost effectiveness of implementing an aging in the community approach to care. It would also assist the Department with being able to allocate resources based on need (see 7.1.5).

7.1.7 Ensure that Adequate Training is provided to Continuing Care Staff

It was noted by Department and HSSA representatives that appropriate training and skill sets are required to provide care for more complex cases in the community and in LTC facilities that are expected to continue and increase as a result of an aging in the community approach (Conclusions 8, 13, 14, 17, and 37). It is recommended that appropriate training be provided to HCC staff and LTC staff as well as to other caregivers in the community to provide them with the skills necessary to provide this care. It is also recommended that the Department explore the possibility of including the training for some of these more complex conditions in the curriculum for nursing students and other health professions trained at education facilities such as Aurora College These skills could also be acquired through the recruitment of staff that already have these skills.

It was also noted that innovative approaches to training may be required to provide training to Continuing Care staff moving forward. One approach that was noted to be successful was contracting Aurora College to come to Behchoko to provide training to staff for the new LTC facility in the community. It is also recommended that the Department examine the potential and feasibility of providing this type of training in other communities in the NWT and in particular for the staff of the new facility that will be opening in Norman Wells.

7.1.8 Consider Use of Regional Specialists to Provide Support for the Treatment of Complex Conditions

The need to have expert specialists to support the provision of care for complex cases such as dementia, wound care, early discharge patients, and palliative care patients was identified by HSSA front line staff and management alike (Conclusions 14, 18 and 37). It is recommended that the Department consider developing a multidisciplinary team of expert health professionals (physicians, nurses and other health professionals) that have expertise in the treatment of complex conditions that can be used as a territorial resource for providing support to staff in each HSSA. Areas of expertise required include geriatrics, geriatric psychiatry, dieticians and rehabilitation professions (OT and/or PT).

The team(s) of professionals could travel on a regular basis to different communities in the NWT throughout the year as well as be made available to provide support to Continuing Care staff via telephone or telehealth. This could provide the territory with the expertise to provide treatment to NWT residents with higher acute and more complex conditions in the community and in LTC facilities and support the ability to have residents age in the community and remain closer to home longer.

7.1.9 Ensure that Continuing Care staff are trained for the Supportive Pathway Model of Care

If the Department intends to proceed with making the Supportive Pathways model a standard for the provision of care to dementia residents (Section 1.2), it is recommended that the Department ensure that appropriate training for this model of care is available to all Continuing Care staff. The waitlist data for the TAC showed that approximately 25% of all LTC applicants assessed for placement into LTC were for dementia (Table 14 and Conclusion 52) and some key informants perceived that the number of clients requiring dementia care in LTC facilities is expected to increase. To ensure consistency in the delivery of care to HCC clients and LTC residents with dementia, it is recommended that all Continuing Care staff receive training on the model for the provision of care to dementia clients in the territory.

7.2 Recommendations for Home and Community Care

The following recommendations are specific to the HCC stream and are aligned with an aging in the community approach.

One of the major limitations for making recommendations for the HCC stream was the availability of HCC utilization data at the community level. Another limitation was the unavailability of data that indicated the level of service required by HCC clients in each HSSA. A third limiting factor was the unavailability of published data regarding staffing mixes for HCC services. These limitations impacted the ability to make definite recommendations on topics of service provider mix.

7.2.1 Improve Consistency of Admissions and Discharge Processes for Home and Community Care in each HSSA

Department and HSSA representatives identified that there was no consistent approach to admitting clients into HCC in the different HSSAs (Conclusion 12). Although the implementation of the Inter-RAI Home Care system (recommendation 7.1.3) would improve the clinical assessments for admission into HCC, it is only part of the admission process.

The YHSSA is implementing a single point of entry approach, which was perceived to be effective by representatives from the Department and the YHSSA. It is recommended that the Department consider implementing a similar single point of entry approach for admitting clients into HCC for the rest of the territory. However, this approach may have to be modified in some HSSAs given the geographic distribution of clients. In addition, the YHSSA has a dedicated resource for admissions, which might not be feasible for all HSSAs.

In order to implement a single point of entry approach for the remaining six HSSAs, it is suggested that one regional admissions coordinator service and be the first point of contact for all six remaining HSSAs based on new admissions data as shown in Table 31 below. The strategy would require the initial assessments to be conducted over the phone by the admissions coordinator. The admissions coordinator could liaise with HSSA staff if more information is required to make a decision. If a more detailed in-person assessment is required, the client could then be referred to a local nurse in their community who would then liaise with the coordinator regarding the final assessment.

Table 31: Proposed Single Point of Entry Region Size and Activity

HSSA	2011/2012 New Admissions	2011/12 Discharges	2011/12 New Admissions	2011/12 Discharges
Remaining HSSAs	142	99	165	68
Yellowknife	367	284	441	371
Total NWT	**509**	**383**	**606**	**439**

It is suggested that the Department consider piloting this approach for a period of two years, and then assess the effectiveness of the approach at that time. The anticipated benefit of the method is an improvement in the consistency with which clients are admitted into HCC in the region by having one person as the initial point of contact rather than multiple people. The success of the approach will be dependent on communication and the sharing of information between the admissions coordinator and staff in the HSSAs, the consistent application of the assessment tool, and a willingness of HSSA staff to comply with the pilot. The implementation of the Inter-RAI Home Care could also improve the success of the pilot, as it provides a more credible and less cumbersome assessment tool for the admissions as well as an electronic platform for the storage and sharing of information.

It is also recommended that the Department review the current process for discharges from HCC in each HSSA. Although there was no feedback provided in the consultations related to discharges, there were 383 discharges from HCC in 2011/12 and 439 in 2012/13. Similar to the need for a consistent admissions process into HCC, there should also be a consistent process for discharging clients out of HCC in each HSSA.

7.2.2 Improve Consistency of Management of HCC Clients

The delivery of HCC services in the NWT was found to be inconsistent (Conclusions 9 and 10). Improving consistency could be achieved through the implementation of the of the new Continuing Care standards (7.1.1), the Inter-RAI Home Care system (7.1.3) and improved performance measurement for the HCC program (7.1.4). In the short-term, consistency could also be improved by having more timely data entry into Health Suite and keeping up to date client charts. It was also suggested that the HCC program implement an electronic pen for charting HCC client information because it can capture the information digitally in real time. It is recommended that the Department conduct a detailed study of the effectiveness and reliability of the digital pen before proceeding with the implementation of this method.

7.2.3 Conduct detailed HCC Review to Determine the Service Provider Mix to Service Higher Acuity Clients in the Home

The service provider mix for the provision of HCC services varies significantly by HSSA (Conclusions 9 and 10). The focus for HCC services in some HSSA has been on home support and personal care services while in other HSSAs the focus has started shifting to the provision of more nursing care for more acute conditions. The treatment of higher acute conditions in the home will allow residents to age in their communities longer before requiring care in an institutional setting.

In order to properly determine the service provider mix required in each HSSA, it is recommended that a more detailed review be conducted of the HCC program in the NWT. In particular, it would be useful to examine the utilization of HCC services by community in each HSSA in order to determine if the staff in each community is working to full capacity. It would also be useful to have a better understanding of the needs for HCC services in each community to determine if the current service provider mixes are appropriate. Based on the data available, it is difficult to determine if the types of HCC provided is being driven by the needs of the residents in the HSSAs or if the staffing mix available is driving the types of services provided to clients (Section 2.1). A detailed review of the HCC program could provide the Department with a better understanding of the HCC needs in communities across the territory and the ratio of nursing, HSW and other staff required to meet those needs to allow residents to age in their communities.

It is suggested that all HSSAs have a minimum of 25% HCC nursing staff to support a goal of aging in the community moving forward. This is aligned with the published proportion of HCC nursing staff in Ontario.[82] The proportion of HCC nurses in other jurisdictions was not available. Based on this ratio, the number of nurses in the BDHSSA, DHSSA and the SHSSA would have to be increased. The role of HSWs in allowing elders to age in the community is also considered to be critical. Although no ratio has been published, it also suggested that the number of HSWs in each HSSA be a minimum of 50% to support an aging in the community approach. Based on this ratio the number of HSWs would have to be increased in the HRHSSA, TCSA and YHSSA. Overall in the NWT, nursing staff currently represent approximately 24% of all HCC staff, HSWs represent 57% of HCC staff, and other staff represents 19% of HCC staff (see Table 28 in Section 6.1.1).

Table 32 compares the projected service provider mix of nurses and HSWs for each HSSA based on the current number of HCC cases and the ratio of staff per 100 HCC clients to actual staffing levels. The number of other staff was not included in the analysis give the large variability of types of staff in this category between the different HSSAs. The table highlights the disparities observed in service provider mix across the NWT and shows that there is a shortage of nurses and/or HSWs in some HSSAs and a surplus of nurses and HSWs in others. It is not recommended at this time that the HCC service provider mix in HSSA be adjusted exactly as outlined in Table 32. However, it is recommended that the

[82] Home Care Nursing in Ontario. Ontario Home Care Association. March 2011.

Department use this comparison as a preliminary guideline of the service provider mix required to support an aging in the community approach to Continuing Care and to identify potential service provider mix gaps in each HSSA that can be used to drive the more detailed HCC review that is being recommended.

Table 32: Comparison of Existing HSSA Staffing to Projected Service Provider Mix for the Present

HSSA	Nursing (FTE)			HSW (FTE)		
	Existing	Projected	Difference	Existing	Projected	Difference
Beaufort-Delta	0.5	3.7	-3.3	15.0	8.7	+6.3
Dehcho	0	3.4	-3.4	7.5	8.0	-0.5
Fort Smith	3.0	1.3	+1.7	3.5	3.0	+0.5
Hay River	4.0	2.9	+1.1	2.5	6.9	-4.4
Sahtu	1.0	1.5	-0.5	7.5	3.6	+3.9
Tlicho	3.5	1.0	+2.5	4.5	2.5	+2.0
Yellowknife	10.0	8.1	+1.9	11.1	18.9	-7.8
Total	**22.0**	**22.0**	**0**	**51.6**	**51.6**	**0**

Although a more detailed review is required to better determine the requirements for HCC services in each HSSA, the future need for HCC services was projected based on the age breakdown of the existing HCC client base and population projection data for each HSSA. Specifically, the number of HCC clients in each HSSA was projected by:

- Estimating the existing proportion of HCC clients that are over the age of 60 by averaging the proportion of HCC clients that are 65 and older and 55 and older. The estimated proportion of HCC clients aged 60 and older was then multiplied by the projected population aged 60 plus to provide an estimate of the HCC requirements for elders.
- The number of HCC clients under the age of 60 was assumed to remain static throughout the projection period, based on the low projected growth for this age demographic.
- The projected number of HCC clients aged 60 plus was added to the estimated number of HCC clients under the age of 60 to determine the total requirement for HCC services in each HSSA.

Then, the existing ratio of nursing staff and HSWs per 100 HCC clients in the NWT was used to project the service provider mix required moving forward in each HSSA. A detailed description of the assumptions and calculations used for projecting the service provider mix in each HSSA is provided in Appendix C.

Figure 19 shows the projected number of nurses and HSWs required moving forward to the year 2031. It should be noted that the number of other staff was not included due to the variability in number and types of positions in this category in each HSSA.

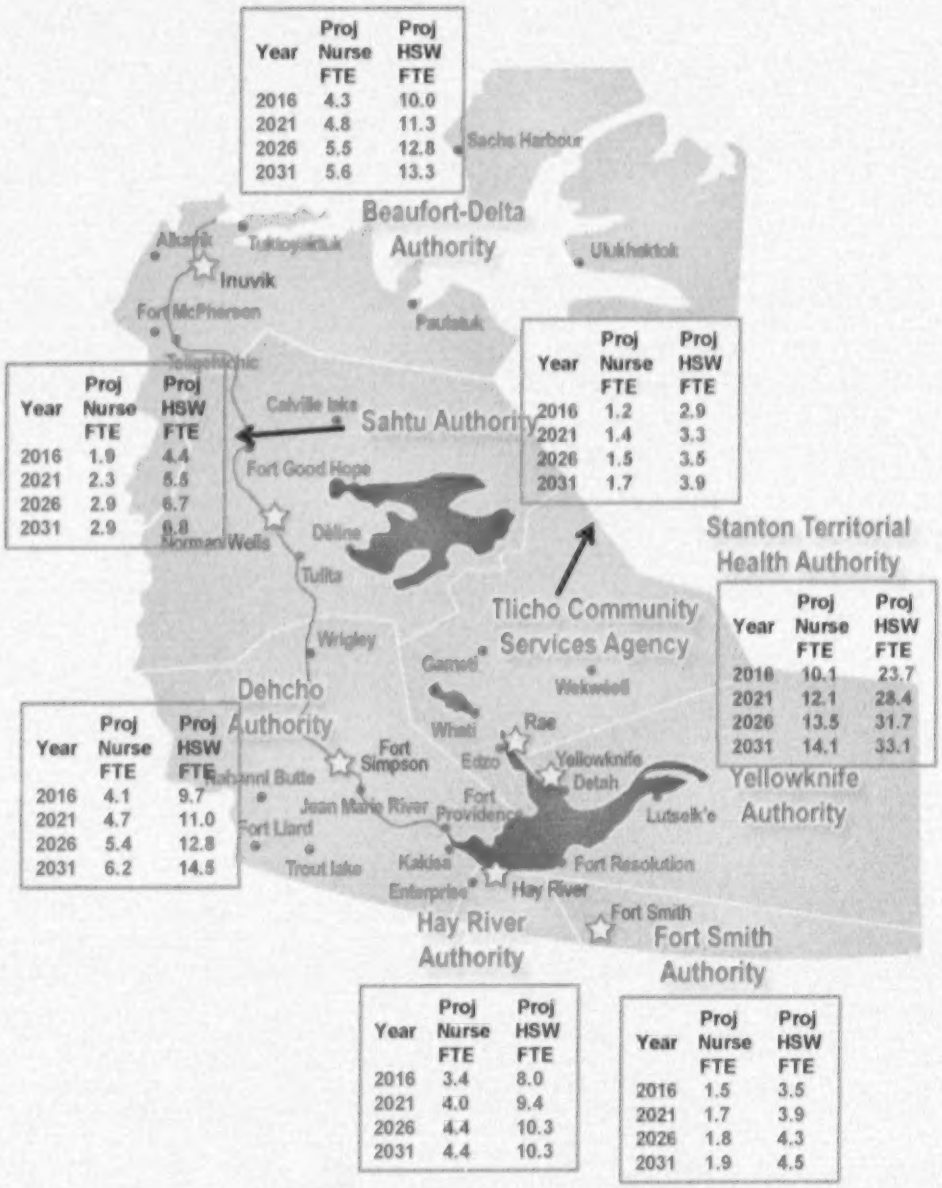
It is recommended that the Department use the projected service provider mix for nurses as a preliminary guideline and starting point to consider the requirements to support an aging in the community approach going forward. As mentioned above, a more detailed review of HCC services in the NWT is recommended to determine the need for HCC services in each HSSA, which could then be used to refine the projected service provider mix in Figure 19.

It should be noted that there are limitations to projections developed in Table 32 and Figure 19 including:

- The projections are based on existing staffing ratios per 100 HCC clients in the NWT. Therefore, they are reflective of the current overall picture in the territory and do not reflect the unique situation in each HSSA.

- An internet search of other jurisdictions in Canada found that there were no published service provider mix ratios for the provision of HCC services.
- The number of HCC cases in each HSSA is based on Health Suite data, which was perceived to have issues related to timeliness and accuracy. The same degree of confidence should be given to the accuracy of the projections developed.

Figure 19: Projected Mix of Nursing and HSW staff to the Year 2031



7.2.4 Define the Scope of Services and Service Limits for HCC Nurses and Home Support Workers

The key informants consulted expressed concern with types of services provided by HSWs in different HSSAs in the NWT, as it was felt that they went beyond the scope of services for HCC (Conclusion 11). It is recommended that the Department define the scope of services for HCC Nurses and HSWs to provide a guideline for which services they can provide and not provide to residents in the NWT. The projected need for HCC services in the future highlights the importance of having a defined scope of services, as the time available to provide services to clients will become more limited for HCC Nurses and HSWs.

The scope of services for HSW equivalents have been defined in some other jurisdictions in Canada including Ontario[83], Nova Scotia[84] and British Columbia[85]. They document the roles and responsibilities and tasks/functions that can be conducted as well as the process for delegating tasks/functions outside of the scope of practice. The Ontario Home Care standards also define service limits for homemaking and personal support services[86], and Manitoba Health provided time standards that they use as a guideline for different homemaking and personal support tasks (see Appendix D). The scope of services for HCC nurses have also been defined in some other jurisdictions in Canada including Ontario[87] and Nova Scotia.[88] The Ontario standards also include service limits for HCC nurses.

It is recommended that the Department use the scope of services developed in other jurisdictions and Manitoba Health data as a guideline for defining the scope of services and service limits for HCC Nurses and HSWs in the NWT. It is also recommended that the scope of services and service limits be developed as part of the detailed HCC review that was recommended in 7.2.3, as it will provide a clearer indication of the types of services that are needed by HCC clients in the different communities in each HSSA as well as the types of services that should not be provided under the HCC program.

7.2.5 Improve Management of HCC Staff

The supervision of HCC varies by each HSSA (Conclusion 16). Some HSSAs have managers or HCC coordinators to provide oversight to HCC staff (BDHSSA, DHSSA, and YHSAA) while other HSSAs have delegated this task to nursing staff including some nurses whose primary responsibility is not HCC. It is recommended that the oversight of HCC in each HSSA be provided a HCC coordinator. It is acknowledged that the case load in some HSSAs is significantly lower than the other HSSAs, and oversight could be provided by a regional coordinator responsible for multiple HSSAs. It is recommended that one regional coordinator could provide oversight for the FSHSSA and HRHSSA and that one regional coordinator could provide oversight for SHSSA and TCSA. Although there are HCC nurses who provide oversight in some of these HSSAs, the regional coordinator could relieve these staff members of their coordinating duties allowing them to focus more time on the provision of care to HCC clients.

In addition to the oversight provided by the regional coordinators, there was concern expressed regarding nursing oversight for HSWs. It is recommended that the requirements for this oversight be determined after the completion of the detailed HCC review in 7.2.3. In order to determine the requirements for nursing oversight of HSWs, the service provider mix in each HSSA would need to be determined, which would be completed after the detailed HCC review. It is acknowledged that the oversight of HSWs could

[83] http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/ccac_7.pdf. Accessed August 15, 2013.
[84] http://www.gov.ns.ca/health/ccs/Scope_of_Practice_CCA.pdf. Accessed August 13, 2013.
[85] http://www.health.gov.bc.ca/library/publications/year/2008/Personal_Assistance_Guidelines.pdf. Accessed August 13, 2013.
[86] http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/ccac_7.pdf. Accessed August 15, 2013.
[87] http://www.health.gov.on.ca/english/providers/pub/manuals/ccac/ccac_7.pdf. Accessed August 15, 2013.
[88] http://www.gov.ns.ca/health/ccs/homeCare/HomeCare_Policy_Manual.pdf. Accessed August 15, 2013.

require additional nursing staff, however the exact number of nursing FTEs required for this cannot be determined at this time.

7.2.6 Implement a More Consistent Application Process for FNIHCC Funding

Considering that the GNWT has just entered into a five year agreement for FNIHCC funding, it is recommended that the Department ensures that it has consistent guidelines and requirements for the provision of FNIHCC funding to ensure that it is providing funding based on need. A review of the contribution agreements for the FNIHCC funding with each HSSA showed that the information describing the background and project being funded was not provided in a consistent format (Conclusion 21). It is also recommended that the contribution agreements have more detailed reporting requirements (Conclusion 22) with clear performance measures that allow the Department to determine if each HSSA has spent the FNIHCC funds appropriately to achieve intended outcomes.

7.2.7 Explore and Consider a Restorative Approach to HCC

It is recommended that the Department explore and consider a restorative approach to delivering HCC services (Conclusion 18). As noted in Section 5.2, restorative approaches to home care can:

- Improve both functional and social status of clients;
- Reduce dependency on home care services; and
- Improve the capacity to cope with the growing demand for home care services.

Both Manitoba and Nova Scotia are incorporating a restorative approach to home care to support their Continuing Care Strategies. It is recommended that the Department also consider a restorative approach to HCC to support its goal of aging in the community.

7.2.8 Continue with Implementation of Respite Services Business Case

The Department recently had a business case developed for a territorial respite services strategy that outlines the roles and responsibilities, staffing requirements and costs for a Territorial Flexible Respite Model (Conclusions 26, 28, 29, 30 and 32). It is recommended that the Department proceed with the implementation of this model and ensures that it is properly integrated and aligned with the recommendations of this study for an aging in the community approach for Continuing Care Services. In particular, the staffing projections in the business case have not been accounted for in the projections for HCC service provider mix in Recommendation 7.2.3. The provision of respite care was identified as being important to providing support for and complimenting Continuing Care services (Conclusion 27) and the Department should proceed with the implementation of the Flexible Respite Model, as it supports elders in being able to age in the community.

7.2.9 Determine need for Palliative Care Services in the NWT

Based on the data available for this study, the projected need for palliative care services could not be determined (Conclusions 34, 35 and 38). It is recommended that the Department work with each HSSA to examine the current use of in-home and in-facility palliative care to determine the need for palliative care services in the NWT. This will impact decisions and planning regarding the allocation of beds for the purpose of palliative care as well as the requirements for training Continuing Care staff and family caregivers in the provision of palliative care.

7.2.10 Continue with Activities Outlined in Palliative Care Logic Model and Develop Palliative Care Plan

The Department has already developed a logic model to support the delivery of palliative care in the NWT (Conclusion 33). It is recommended that the Department continue with implementing the activities in the

logic model and develop a more formal plan for the delivery of palliative care in the NWT after completing recommendation 7.2.9. The current logic model provides a framework outlining the outcomes that the NWT would like to achieve related to palliative care. The completion of recommendation 7.2.9 will provide the Department with the information required for developing a palliative care plan that outlines the need for palliative care, staffing requirements and infrastructure to meet those needs, and the training and skills required to provide palliative care services.

7.2.11 Develop Standards for Delivery of Palliative Care

Some HSSAs (HRHSSA and YHSSA) indicated that they had developed standards, guidelines and in some cases manuals for the delivery of palliative care in their HSSAs based on the Victoria Hospice (Conclusion 36). It is recommended that the Department work with the HRHSSA and YHSSA to review the standards and guidelines that have already been developed and develop a set of territorial wide standards and guidelines for the delivery of palliative care in the territory. Since the standards developed are based on the practices of the Victoria Hospice, they provide a good starting point for developing the territorial wide standards.

7.2.12 Conduct a Detailed Needs Assessment for Independent Living with HCC Supports.

It is recommended that a detailed needs assessment be conducted by the Department and the NWTHC to determine the need for affordable independent living with HCC supports (Conclusion 24). It is also recommended that this study include an analysis of capital and operating costs to support the needs for independent living. This study is required to determine the number of independent housing units needed now and for the future for those aged 60 plus and for persons with disabilities, and the requirements for HCC staff and other resources to provide supports to those individuals in order to support an aging in the community approach. This study is also required to determine how independent living with HCC supports will fit into the overall Continuing Care strategy for the NWT and could impact the assumptions and projections made in this study regarding need for HCC and LTC services.

It is also recommended that the best practice research from other jurisdictions (Section 5.2) be considered when conducting the needs assessment and developing an Independent Living with HCC Supports strategy.

7.2.13 Explore Opportunities to enhance Collaboration and Partnership between the Department and NWTHC

It is recommended that opportunities to enhance collaboration between the Department and NWTHC be explored (Conclusion 24). The successful implementation of an Independent Living with HCC Supports strategy that supports aging in the community will require significant participation by both parties which in turn will require a strong partnership with effective communication and collaboration.

7.3 Recommendations for Long-Term Care

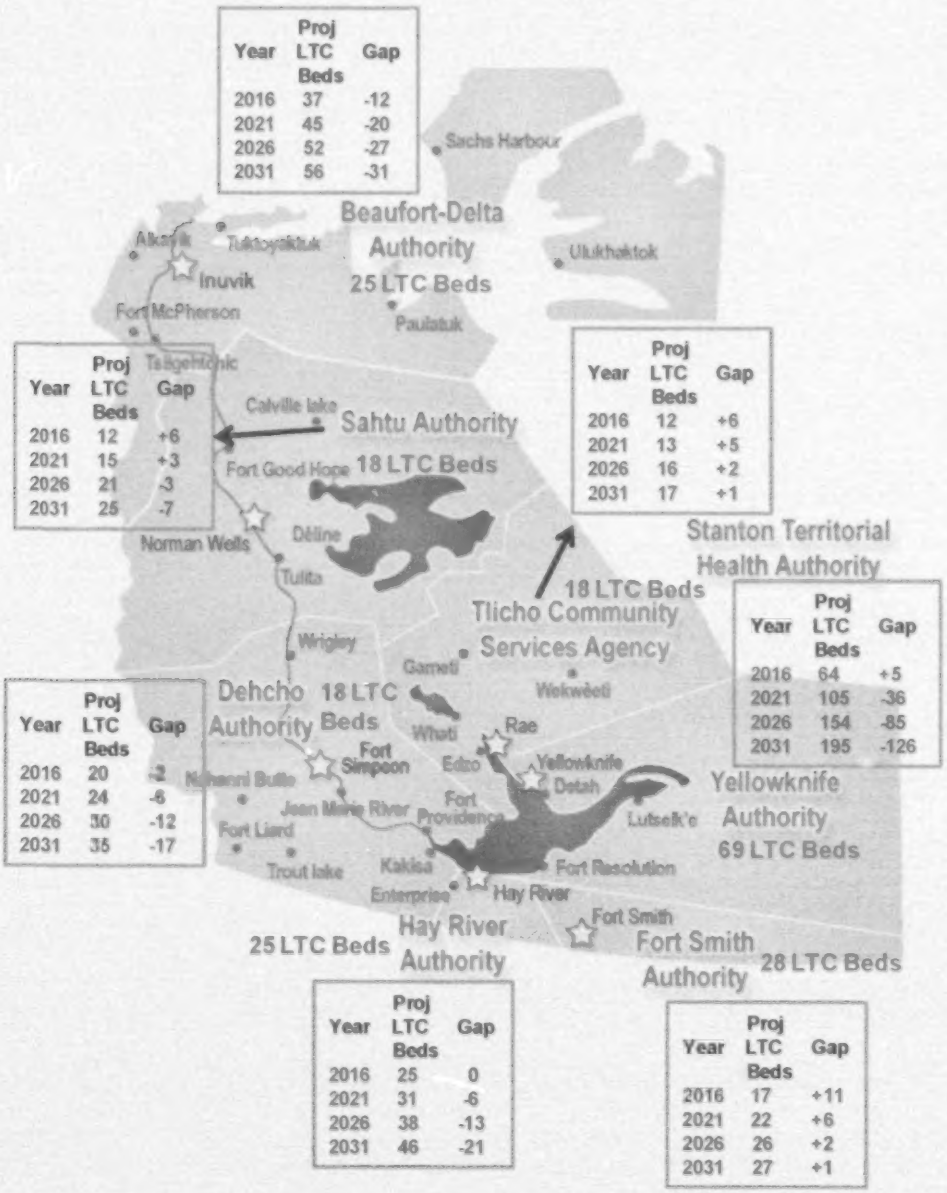
The following recommendations are specific to the LTC stream and are aligned with an aging in the community approach to Continuing Care.

7.3.1 Ensure Sufficient Supply of LTC Beds

The demand for LTC beds is projected to grow in the NWT (Conclusions 45 and 46). Figure 20 shows the LTC beds requirements for each HSSA to the year 2031. It is recommended that the projected bed requirements be used as a guideline for LTC bed planning in the territory to the year 2021. The margin of error of the LTC bed projections to the year 2021 is lower and approximately plus or minus 10%; however, the margin of error to the year 2031 is higher and is approximately plus or minus 20%. It is also

recommended that the Department revise the LTC bed projections for the NWT in five years, as the population projections for the 70 plus age group in the NWT may change as well as the methods for projecting LTC bed requirements.

Figure 20: Projected LTC Bed Requirements in the NWT to the Year 2031



The largest bed deficit in the NWT is projected for the YHSSA. By the year 2021, there is a projected deficit of 36 LTC beds. The projected deficit is 46 LTC beds if the 10 extended care beds at Stanton are removed from the current bed base of 69 LTC beds. It is recommended that the YHSSA be the first region to be considered for additional LTC beds if the Department plans on adding additional LTC beds in

the territory. The Avens group has developed a business plan for the development of new LTC beds in Yellowknife, and should be considered as one option for expanding the number of LTC beds in the area.

The BDHSSA has the second largest projected LTC deficit by 2021. It is projected that the HSSA will require an additional 20 LTC beds. Given that the Department has been using an 18 bed functional plan for developing new facilities, the BDHSSA should given consideration right behind the YHSSA for the addition of LTC beds in the NWT, as it is the only region other than the Yellowknife with a projected bed deficit that is larger than 18 LTC beds.

The LTC bed projection also provides support for the replacement of the 10 LTC beds that are to be eliminated from the closure of H.H. Williams in Hay River. Assuming that these beds are replaced by 2016, there is no projected LTC bed deficit in Hay River justifying the need to replace these beds. By 2021, the deficit is projected to be 6 LTC beds.

The total projected requirement for LTC beds in the NWT in 2021 is 255 beds, resulting in a total deficit of 54 LTC beds. Of the 255 projected LTC beds, 54 are projected to be required for dementia care. Based on the current compliment of 24 beds at the Territorial Dementia Facility, there will be a deficit of 30 dementia beds in the NWT in 2021.

As noted in Section 4.2 above, the LTC bed projection model used for the Dehcho, Sahtu and Tlicho HSSAs reflect a modest shift towards home care and supported living options and the projection model for the Beaufort-Delta, Fort Smith, Hay River and Yellowknife HSSAs reflect a more aggressive shift towards expanding home care and supported living options. These models are consistent with the GNWT's goals of aging in the community and a shift away from providing care in an institutional setting. Despite there being a shift towards increasing the level of care provided to clients in the home, LTC bed facilities will remain an important component along the continuum of care to provide care to those with a level of care that can no longer be managed in the home.

7.3.2 Continue to Implement Staffing Standards

The Department has developed a standard of 3.6 hours of direct care and a ratio of 20% nurses and 80% RCA for staffing LTC facilities (Conclusions 55 and 56). It is recommended that the Department maintain this standard and staffing ratio. The current standard is consistent with established standards in other jurisdictions and the staffing ratio was developed based on research from other jurisdictions and an in-depth risk analysis that substantiated this standard provides for an adequate quality of care and minimized potential for risk.

7.3.3 Regular Monitoring of LTC Facility Utilization and Admissions to Acute Care

One of the expected outcomes from an aging in the community approach is that the level of care and acuity of those placed into LTC will increase (Conclusions 41, 42, 43, and 44). The treatment of a larger number of residents requiring a high level of care in LTC facilities could result in a need for an increase in nursing care. It is recommended that the utilization at LTC facilities and admissions to acute care be monitored on a regular basis. This includes monitoring the level of care and acuity of residents as well as the ability to provide quality care with existing staffing levels.

7.3.4 Examine Costs for LTC Facilities that Consistently Operate at a Deficit

The Department is considering examining the costs and staffing mix at the Northern Lights Special Care Home because it has operated at a deficit for multiple years. It is recommended that the Department proceed with this review as well as review other facilities like the Fort Simpson facility and the Jimmy Erasmus facility to determine the drivers for cost overruns at these facilities (Conclusions 58 and 59).

Although the Jimmy Erasmus facility will be replaced by the new 18 bed facility in Behcoko, the review could be beneficial to ensure that the costs are managed appropriately in the new facility.

7.3.5 Ensure that all LTC Facilities are accredited in the NWT

Currently all but two LTC facilities in the NWT are accredited (Conclusion 54). The two facilities not accredited are Jimmy Erasmus and the Fort Simpson facilities. Considering that the Jimmy Erasmus facilities will soon be replaced by the new LTC facility in Behchoko, it is not effective to have this facility accredited. However, it is recommended that the Fort Simpson LTC facility apply for accreditation. It is also recommended that the new facilities being developed in Behchoko and Norman Wells also be accredited once they have been in operation for two years. The accreditation process ensures requires adherence to a consistent set of standards which should enhance the consistency with which care is provided at the LTC facilities in the NWT.

7.3.6 Continue use of TAC for Management of LTC Beds in the NWT

It is recommended that the Department continue using the TAC to manage LTC beds as a territorial resource. The committee was perceived to be effective and to provide a structured process for the placement of applicants into LTC beds (Conclusion 48). The waitlist data also demonstrated that the TAC was placing applicants with the appropriate assessed level of care into LTC beds (Conclusion 51). The TAC has provided consistency in the management of LTC beds and should continue.

7.3.7 Allow the TAC to use the Inter-RAI Home Care System for LTC Placement Assessments

If the Department proceeds with the implementation of the Inter-RAI Home Care System (see 7.1.3), it is recommended that TAC use the system for LTC placement assessments (Conclusion 49). This would allow for improved continuity of care between the HCC and LTC streams as well as provide a more credible and less cumbersome tool for making LTC assessments. See recommendation 7.1.3 for a description of the Inter-RAI Home Care tool.

7.4 Recommendations for Extended Care

The following recommendations are specific to extended care. There were limitations in the analysis of extended care services due to the limited amount of data available for extended care services as well as a limited amount of information published regarding best practices for extended care.

7.4.1 Continue to Allocate 10 Beds for Extended Care in the NWT

Based on the utilization data for the extended care beds at Stanton, and the TAC waitlist, the needs of extended care patients are being met by the 10 extended care beds in the NWT (Conclusion 63). In fact, these 10 beds have not been utilized to full capacity. The average level of care of extended care patients was 4.0 in 2011/2012 and 4.5 in 2012/2013 and the average level of care of those placed into extended care by the TAC was 4.3 (Conclusion 63). In total, the TAC placed a total of 16 applicants into extended care at Stanton.

The Continuing Care Level of Services framework does define extended care patients as requiring a level of care of 5 and as persons with complex conditions requiring 24-hour nursing care, support from other health professionals and medical supervision. Using the TAC waitlist data as a proxy, shows that 4% (7 of a total of 175, see Table 13) of applicants assessed by the TAC required a level of care of 5. Considering that the projected need for LTC beds will be 255 in the NWT by the year 2021, the projected need for extended care beds will be 10 (255 x 4%). Therefore, it is recommended that the Department continue to allocate 12 beds for extended care as it is sufficient to meet the needs for extended care through to the year 2021.

7.4.2 Continue to Locate Extended Care Beds in Yellowknife

Most key informants indicated that the extended care beds in the NWT needed to be located in Yellowknife close to Stanton so that medically complex clients have access to specialized services (Conclusions 61 and 66). It is recommended that the extended care beds continue to be located in Yellowknife in close proximity to Stanton. The redevelopment of Stanton provides an opportunity for the Department to determine the most appropriate location for the 12 extended care beds.

7.4.3 Continue with Current Staffing Mix for Extended Care

The ECU at Stanton is currently staffed to provide 6.6 hours of direct care and with a staffing mix of 85% nurses (10 FTE) and 15% nursing aides (1.75 FTE) (Conclusion 65). Although there is no best practice published regarding nursing ratios or hours of direct care for extended care, the Canadian Federation of Nurses published a study that recommends a patient to nurse ratio of 4:1 for most hospital inpatient units and a ratio of 2.1 for critical care units.[89] The patient to nurse ratio for the ECU was calculated to be 5.4:1 ((24 hours x 12 beds x 365 days = 105,120 patient hours)/(10 FTE nurses x 1,950 hours/year = 19,500 hours) = 5.4:1). This assumes that the unit is operating at 100% occupancy. However, considering that the unit operated at 76% occupancy in 2012/2013, the effective patient to nurse ratio would have been 4.1:1, in line with the recommended ratio. Therefore, it is recommended that the ECU continue with its current level of hours of care and staffing mix. If the unit starts operating closer to capacity on a regular basis, then it is recommended that it review if the needs of extended care patients are continuing to be met and add more nursing staff if required.

[89] http://www.thinknursing.ca/sites/thinknursing.ca/files/Nurse_Patient_Ratios.pdf. Accessed August 14, 2013.

8.0 Action Plan/Prioritized Recommendations

The 32 recommendations for updating the Continuing Care Strategy in the NWT have been categorized into two levels of priority: immediate; and intermediate.

1. **Immediate priorities** – The Department should consider implementing immediate priority recommendations within the next 2 years. These recommendations are considered critical to implementing a Continuing Care strategy supports an aging in the community objective. In some instances, the implementation of these recommendations is required before the Department can proceed with the implementation of other recommendations.
2. **Intermediate priorities** – The Department should consider implementing these recommendations within the next 3-5 years. These are lower priority recommendations and/or require the completion of an immediate recommendation before they can be implemented.

Table 33 summarizes the recommendations by type and level of priority.

Table 33: Priority of Recommendations

Recommendation	Immediate	Intermediate
Entire Continuum of Care		
7.1.1 – Complete Continuing Care Standards Manual	✓	
7.1.2 – Continue use of Levels of Service Framework	✓	
7.1.3 – Proceed with Business Case for Inter-RAI	✓	
7.1.4 – Determine Performance Measurement	✓	
7.1.5 – Base Funding and Service Delivery on Need		✓ - requires 7.1.4 and 7.1.6
7.1.6 – Conduct Detailed Financial Review	✓	
7.1.7 - Adequate Training for Continuing Care Staff		✓ - requires 7.2.3 for HCC staff
7.1.8 – Use of Regional Specialists		✓ - requires 7.2.3 for HCC and 7.2.9 for palliative care
7.1.9 - Ensure that Continuing Care Staff are trained for Supportive Pathways		✓
Home and Community Care		
7.2.1 – Consistency of HCC Admissions Process		✓ - assisted by 7.1.3
7.2.2 – Consistency of HCC Client Management		✓ - requires 7.1.1 and 7.2.3, and assisted by 7.1.3 and 7.1.4
7.2.3 – Conduct Detailed HCC Review to Determine Service Provider Mixes	✓	

7.2.4 – Define Scope of Services and Service Limits for HSWs		✓ - requires 7.2.3 and assisted by 7.1.4
7.2.5 – Improve Management of HCC Staff	✓ - requires 7.2.3 to complete nursing oversight of HSW component	
7.2.6 – Consistent Application Process for FNIHCC Funding	✓	
7.2.7 - Consider a restorative approach to HCC		✓ - assisted by 7.2.3
7.2.8 - Continue with Implementation of Respite Services Business Case		✓ - requires 7.2.3
7.2.9 – Determine Need for Palliative Care	✓	
7.2.10 – Palliative Care Plan		✓ - requires 7.2.9, assisted by 7.2.3
7.2.11 – Develop Standards for Palliative Care		✓ - assisted by 7.2.9 and 7.2.10
7.2.12 – Conduct Detail Needs Assessment for Independent Living with HCC Supports	✓	
7.2.13 – Improve Collaboration and Partnership between Department and NWTHC	✓	
Long-Term Care		
7.3.1 – Ensure Sufficient Supply of LTC Beds		✓ - assisted by 7.1.6, 7.2.3 and 7.2.12
7.3.2 – Continue to Implement Staffing Standards	✓	
7.3.3 – Regular Monitoring of LTC Facility Utilization and Admissions to Acute Care		✓ - assisted by 7.1.4
7.3.4 – Examine Costs for LTC Facilities Operating with a Deficit	✓	
7.3.5 – Ensure Accreditation of all LTC Facilities		✓
7.3.6 – Continue to use TAC	✓	
7.3.7 – Allow TAC to use Inter-RAI for Assessments		✓ - requires 7.1.3
Extended Care		
7.4.1 – Continue to Allocate 10 Beds for Extended Care	✓	
7.4.2 – Continue to Locate Extended Care Beds in Yellowknife		✓
7.4.3 – Continue with Current Staff Mix for Extended Care	✓	

Appendix A

Interview and Focus Group Question Guides

Department Representatives

1. How would you describe the delivery of Continuing Care Services (Home Care, Long-term care, Supported Living) in the NWT? Specifically, what is working well, and what are the challenges?

2. In your mind, what are the priorities for Continuing Care Services in the NWT? Are these priorities being met?

3. How would you describe the current state of the home and community care services delivered across the NWT? What is working well, and what are the challenges?
    - What is your perspective on equity of services in each community? Are there options for service delivery that you think would work that are based on the size of the community and its capacity to deliver services?
    - Are there disparities in home care services by region and/or community? If yes, what are the disparities? What is driving these disparities?
    - What has been the impact of acute home care and early discharge on chronic continuous care?
    - Are there any processes or services that would improve patient outcomes when they transition from hospital to home and community care?
    - Are the infrastructure and supports in place to allow seniors in smaller communities to remain in their homes/communities longer?

4. I would like to talk to you about service provider mixes. As you know services can be and are provided by a variety of service provider types.
    - Can you please tell me about what is currently taking place in NWT in regard to the provision of services?
        i. What is the current service provider mix? (Pros and cons)
    - What types of service limits do you think should be in place for different providers such as nursing, home support and homemaker functions for example?
    - Are there any best practices that you are aware of related to staffing models, focus and limits of service that the NWT should consider for delivering home and community care?

5. How would you describe the current state of the long-term care services being delivered in the NWT? What is working well and what has been challenging?
    - Are there enough beds to meet current demand? Are the beds located in the appropriate locations? Why?
    - Are there any processes or services that would improve patient outcomes when they may have to transition from hospital to long term care?

6. Has the Territorial Admissions Committee been effective in the placement of patients into long-term care beds? Why or Why Not? Has the placement of patients into long-term care beds improved since the establishment of the committee? What could be improved?

7. Are the current needs for extended care being met in the NWT? Why or why not? Are the beds located in the appropriate locations?

8. Are the current needs for respite and palliative care being met in the NWT? Why? What could be improved?

    - Are the needs being met for LTC respite and palliative beds? What are the challenges?

9. The population of individuals aged 60+ in the NWT is projected to approximately double by the year 2031. Is NWT in a position to meet the projected increase in demand for Continuing Care Services? Why or Why not?

    - If no, what infrastructure and supports (funding, human resources, and bed numbers) will be needed to meet this demand? (Probe for Long-term care, home and community care, supported living and extended care).
    - Will the NWT's approach to delivering Continuing Care Services need to change? How? (probe staffing mix, service mix)

10. What do you think the key priorities should be for an updated continuing care strategy? (Probe, update long-term care capacity, improvements to home care delivery, supported living capacity, extended care services, palliative care services, respite care).

HSSA CEOs

1. To begin, it would be helpful for me to know more about your role regarding the administration and delivery of Continuing Care Services (Home Care, Long-term care, Supported Living) in the NWT?

2. How would you describe the delivery of Continuing Care Services in your HSSA? Specifically, what is working well, and what are the challenges?

3. In your mind, what are the priorities for Continuing Care Services in your HSSA? The NWT? Are these priorities being met?

4. How would you describe the current state of the home and community care services delivered across the NWT? What is working well, and what are the challenges?
    - What is your perspective on equity of services in each community? Are there options for service delivery that you think would work that are based on the size of the community and its capacity to deliver services?
    - Are there disparities in home care services by region and/or community? If yes, what are the disparities? What is driving these disparities?
    - What has been the impact of acute home care and early discharge on chronic continuous care?
    - Are there any processes or services that would improve patient outcomes when they transition from hospital to home and community care?
    - Are the infrastructure and supports in place to allow seniors in smaller communities to remain in their homes/communities longer?

5. I would like to talk to you about service provider mixes. As you know services can be and are provided by a variety of service provider types.
    - Can you please tell me about what is currently taking place in NWT in regard to the provision of services?
        i. What is the current service provider mix? (Pros and cons)
    - What types of service limits do you think should be in place for different providers such as nursing, home support and homemaker functions for example?
    - Are there any best practices that you are aware of related to staffing models, focus and limits of service that the NWT should consider for delivering home and community care?

6. How would you describe the current state of the long-term care services being delivered in your HSSA? The NWT? What is working well and what has been challenging?
    - Are there enough beds to meet current demand? Are the beds located in the appropriate locations? Why?
    - Are there any processes or services that would improve patient outcomes when they may have to transition from hospital to long term care?

7. Has the Territorial Admissions Committee been effective in the placement of patients into long-term care beds? Why or Why Not? Has the placement of patients into long-term care beds improved since the establishment of the committee? What could be improved?

8. Are the current needs for extended care being met in your HSSA? The NWT? Why or why not? Are the beds located in the appropriate locations?

9. Are the current needs for respite and palliative care being met in your HSSA? The NWT? Why or why not? What could be improved?

    - Are the needs being met for LTC respite and palliative beds? What are the challenges?

10. The population of individuals aged 60+ in the NWT is projected to approximately double by the year 2031. Is your HSSA in a position to meet the projected increase in demand for Continuing Care Services? The NWT? Why or Why not?

    - If no, what infrastructure and supports (funding, human resources, and bed numbers) will be needed to meet this demand? (Probe for Long-term care, home and community care, supported living and extended care).
    - Will the NWT's approach to delivering Continuing Care Services need to change? How? (probe staffing mix, service mix)

11. What do you think the key priorities should be for an updated continuing care strategy? (Probe, update long-term care capacity, improvements to home care delivery, supported living capacity, extended care services, palliative care services, respite care).

Avens CEO

1. To begin, it would be helpful for me to know more about your role regarding the administration and delivery of Continuing Care Services (Home Care, Long-term care, Supported Living)?

2. How would you describe the delivery of Continuing Care Services in the NWT? Specifically, what is working well, and what are the challenges?

3. In your mind, what are the priorities for Continuing Care Services in the NWT? Are these priorities being met?

4. How would you describe the current state of the home and community care services delivered across the NWT? What is working well, and what are the challenges?
    - What is your perspective on equity of services in each community? Are there options for service delivery that you think would work that are based on the size of the community and its capacity to deliver services?
    - Are there disparities in home care services by region and/or community? If yes, what are the disparities? What is driving these disparities?
    - What has been the impact of acute home care and early discharge on chronic continuous care?
    - Are there any processes or services that would improve patient outcomes when they transition from hospital to home and community care?
    - Are the infrastructure and supports in place to allow seniors in smaller communities to remain in their homes/communities longer?

5. I would like to talk to you about service provider mixes. As you know services can be and are provided by a variety of service provider types.
    - Can you please tell me about what is currently taking place in NWT in regard to the provision of services?
        i. What is the current service provider mix? (Pros and cons)
    - What types of service limits do you think should be in place for different providers such as nursing, home support and homemaker functions for example?
    - Are there any best practices that you are aware of related to staffing models, focus and limits of service that the NWT should consider for delivering home and community care?

6. How would you describe the current state of the long-term care services being delivered at Avens? The NWT? What is working well and what has been challenging?
    - Do you have enough beds to meet current demand? Why?
    - Are the long-term beds located in the NWT in the appropriate locations? Why?
    - Are there any processes or services that would improve patient outcomes when they may have to transition from hospital to long term care?

7. Has the Territorial Admissions Committee been effective in the placement of patients into long-term care beds? Why or Why Not? Has the placement of patients into long-term care beds improved since the establishment of the committee? What could be improved?

8. Are the current needs for extended care being met in the NWT? Why or why not? Are the beds located in the appropriate locations?

9. Are the current needs for respite and palliative care being met in the NWT? Why? What could be improved?

    - Are the needs being met for LTC respite and palliative beds? What are the challenges?

10. The population of individuals aged 60+ in the NWT is projected to approximately double by the year 2031. Is Avens in a position to meet the projected increase in demand for long-term care services? Is the NWT in a position to meet the projected increase for Continuing Care Services? Why or Why not?

    - If no, what infrastructure and supports (funding, human resources, and bed numbers) will be needed to meet this demand? (Probe for Long-term care, home and community care, supported living and extended care).
    - Will the NWT's approach to delivering Continuing Care Services need to change? How? (probe staffing mix, service mix)

11. What do you think the key priorities should be for an updated continuing care strategy? (Probe, update long-term care capacity, improvements to home care delivery, supported living capacity, extended care services, palliative care services, respite care).

Continuing Care and Primary Care Staff Focus Group

1. Tell me a little about your roles in the delivery of Continuing Care Services? (to understand the audience)

2. How would you describe the delivery of ***Continuing Care Services*** (Home Care, Long-term care, Supported Living) in the NWT? What is working well? What have been the challenges?

3. In your mind, what are the priorities for Continuing Care Services in the NWT?

    - Are these priorities being met?

4. How would you describe the current state of the ***home and community care services*** delivered across the NWT? What is working well, and what are the challenges?

    - What is your perspective on equity of services in each community? Are there options for service delivery that you think would work that are based on the size of the community and its capacity to deliver services?
    - Are there disparities in home care services by region and/or community? If yes, what are the disparities? What is driving these disparities?
    - What has been the impact of acute home care and early discharge on chronic continuous care?
    - Are there any processes or services that would improve patient outcomes when they transition from hospital to home and community care?
    - Are the infrastructure and supports in place to allow seniors in smaller communities to remain in their homes/communities longer?

5. I would like to talk to you about ***service provider mixes***. As you know services can be and are provided by a variety of service provider types.

    - Can you please tell me about what is currently taking place in NWT in regard to the provision of services?
        i. What is the current service provider mix? (Pros and cons)
    - What types of service limits do you think should be in place for different providers such as nursing, home support and homemaker functions for example?
    - Are there any best practices that you are aware of related to staffing models, focus and limits of service that the NWT should consider for delivering home and community care?

6. In regard to the delivery of ***long-term care services***? What is working well and what has been challenging?

    - Are there enough beds to meet current demand? Are the beds at long-term care facilities fully occupied on a regular basis?
    - Is the staffing mix appropriate? Why? What could be improved?
    - Do you have the resources and supports required to provide quality services? Why? What could be improved?
    - Are there any processes or services that would improve patient outcomes when they may have to transition from hospital to long term care?

7. In your opinion, has the ***Territorial Admissions Committee*** been effective in the placement of patients into long-term care beds? Why or Why Not?

    - Has the placement of patients into long-term care beds improved since the establishment of the committee? What could be improved?

8. Based on your experience, are the current needs for ***extended care*** being met? Why or why not? Are the beds located in the appropriate locations?

9. Are the current needs for ***respite and palliative care*** being met? Why or why not? What could be improved?

    - Are the needs being met for LTC respite and palliative beds? What are the challenges?

10. The population of individuals aged 60+ in the NWT is projected to approximately double by the year 2031. Is the NWT in a position to meet the ***projected increase in demand*** for Continuing Care Services? Why or Why not?

    - If no, what will be needed to meet this demand? (Probe for long-term care, home and community care, supported living and extended care).
    - Will the NWT's approach to delivering Continuing Care Services need to change? How? (probe staffing mix, service mix)

11. What do you think the ***key priorities*** should be for an updated continuing care strategy? (Probe, update long-term care capacity, improvements to home care delivery, supported living capacity, extended care services, palliative care services, respite care).

Continuing Care Members Focus Group

1. To begin, it would be helpful for me to know more about your role regarding the administration and delivery of Continuing Care Services (Home Care, Long-term care, Supported Living)?

2. How would you describe the delivery of ***Continuing Care Services*** in your HSSA? The NWT? What is working well? What have been the challenges?

3. In your mind, what are the priorities for Continuing Care Services in your HSSA? The NWT? Are these priorities being met?

4. How would you describe the current state of the ***home and community care services*** delivered across the NWT? What is working well, and what are the challenges?
    - What is your perspective on equity of services in each community? Are there options for service delivery that you think would work that are based on the size of the community and its capacity to deliver services?
    - Are there disparities in home care services by region and/or community? If yes, what are the disparities? What is driving these disparities?
    - What has been the impact of acute home care and early discharge on chronic continuous care?
    - Are there any processes or services that would improve patient outcomes when they transition from hospital to home and community care?
    - Are the infrastructure and supports in place to allow seniors in smaller communities to remain in their homes/communities longer?

5. I would like to talk to you about ***service provider mixes.*** As you know services can be and are provided by a variety of service provider types.
    - Can you please tell me about what is currently taking place in NWT in regard to the provision of services?
        i. What is the current service provider mix? (Pros and cons)
    - What types of service limits do you think should be in place for different providers such as nursing, home support and homemaker functions for example?
    - Are there any best practices that you are aware of related to staffing models, focus and limits of service that the NWT should consider for delivering home and community care?

6. In regard to the delivery of ***long-term care services***? What is working well and what has been challenging?
    - Are there enough beds to meet current demand? Are the beds at long-term care facilities fully occupied on a regular basis?
    - Is the staffing mix appropriate? Why? What could be improved?
    - Do you have the resources and supports required to provide quality services? Why? What could be improved?
    - Are there any processes or services that would improve patient outcomes when they may have to transition from hospital to long term care?

7. In your opinion, has the ***Territorial Admissions Committee*** been effective in the placement of patients into long-term care beds? Why or Why Not?

    - Has the placement of patients into long-term care beds improved since the establishment of the committee? What could be improved?

8. Are the current needs for ***extended care*** being met in your HSSA? The NWT? Why or why not? Are the beds located in the appropriate locations?

9. Are the current needs for ***respite and palliative care*** being met in your HSSA? The NWT? Why or why not? What could be improved?

    - Are the needs being met for LTC respite and palliative beds? What are the challenges?

10. The population of individuals aged 60+ in the NWT is projected to approximately double by the year 2031. Is your HSSA in a position to meet the ***projected increase in demand*** for Continuing Care Services? The NWT? Why or Why not?

    - If no, what infrastructure and supports (funding, human resources, and bed numbers) will be needed to meet this demand? (Probe for Long-term care, home and community care, supported living and extended care).
    - Will the NWT's approach to delivering Continuing Care Services need to change? How? (probe staffing mix, service mix)

11. What do you think the ***key priorities*** should be for an updated continuing care strategy? (Probe, update long-term care capacity, improvements to home care delivery, supported living capacity, extended care services, palliative care services, respite care).

NWTHC Focus Group

1. To begin, it would be helpful for me to know more about your role with NWTHC?

2. What is the NWTHC's role in the administration and delivery of continuing care services in the NWT?

3. Are the ***continuing care services*** (Independent Living with Supports) provided by the NWTHC well integrated with the other services provided along the continuum of care such as home and community care and long-term care? Why or why not? How could this be improved?

4. How would you describe the current state of the ***home and community care services*** delivered across the NWT? What is working well, and what are the challenges?
    - What is your perspective on equity of home and community care services in each community? Are there options for service delivery that you think would work that are based on the size of the community and its capacity to deliver services?
    - Are there disparities in home care services by region and/or community? If yes, what are the disparities? What is driving these disparities?
    - Are the infrastructure and supports in place to allow seniors in smaller communities to remain in their homes/communities longer?

5. How would you describe the current state of ***independent living with supports for seniors*** in the NWT? What is working well? What have been the challenges?
    - Are there enough independent living units for seniors to meet current demand? If no, what is required?
    - Are the resources and supports available to allow seniors to stay in independent living facilities? If no, what resources and supports are required (staffing, funding, equipment, other)?
    - Are you familiar with any best practices or approaches that have worked well in other jurisdictions?
    - Are there opportunities to improve the collaboration between the NWTHC and Department to allow seniors to live in independent living facilities longer? What are they?

6. The population of individuals aged 60+ in the NWT is projected to approximately double by the year 2031. Is NWTHC in a position to meet the ***projected increase in demand*** for independent living with supports for seniors? Why or Why not?
    - If no, what infrastructure and supports (funding, human resources, independent living unit stock, and supports for independent living) will be needed to meet this demand?
    - Will the NWT's approach to delivering Continuing Care Services need to change? How? (service mix, staffing mix, more service integration between NWTHC and Department)

7. What do you think the ***key priorities*** should be for an updated continuing care strategy? (Probe, update number of independent living units for seniors, improvements to supports for independent living facilities, improvements to home care delivery, update long-term care capacity)

Appendix B

Perfromance Measurement Best Practices and Critical Success Factors

Indicator Definitions and Fundamentals[90]

Indicators provide critical information on performance, achievement and accountability, which is the cornerstone of effective monitoring and evaluation. In addition, the data from indicators provide the strategic insights that are essential for the effective management of a health system. To be valuable, indicators need to be of high quality and able to collect the right data in the right place at the right time.

What is an Indicator

Fundamentally, an indicator provides a sign or a signal that something exists or is true. It is used to show the presence or state of a situation or condition. In the context of monitoring and evaluation, an indicator is a quantitative metric that provides information to monitor performance, measure achievement and determine accountability. It is important to note that a quantitative metric can be used to provide data on the quality of an activity, project or program.

A good indicator should be clear and concise. It should focus on a single issue that provides relevant information on a situation; particularly information that provides the strategic insight required for effective planning and sound decision-making. Good indicators are also defined by the feasibility of collecting meaningful and credible data for them. In addition, good indicators should actually and accurately measure what they claim to measure. If it is not feasible to collect data for an indicator, or the data that can be collected are not meaningful, the indicator will have little or no utility. Any indicator is only as valuable as the quality of the data it uses and it is crucial that the data are valid, reliable and not biased.

An important but often-overlooked fact about indicators is that they merely indicate. They do not capture or convey the many dimensions of a given situation and/or activity. They are directional such that they provide basic information on the past, present and possible future course of an activity, program and/or behaviour. They are also very context-specific such that higher values or lower values can be either good or bad, depending on the situation. The desired direction of the indicator (i.e. an increase or decrease) is usually determined when the indicator is selected and before data collection begins.

Indicators are not designed to replace more detailed investigations of specific issues, nor should they be used to do so. Consequently, information generated by indicators should always be interpreted within the broader context of the situation and supplemented where necessary by special studies, other evaluation activities and other types of data. Indicators are an essential part of effective monitoring and evaluation. They can provide vital information on performance, achievement and accountability. However, indicators are only one part of a comprehensive accountability framework. They are only one method for collecting and analyzing data and it is imperative that they be used when and where they provide meaningful information and insight.

Essential Components of an Indicator

The following are critical components of an indicator:

- The indicator has a clearly stated title and definition.
- The indicator has a clearly stated purpose and rationale.
- The method of measurement for the indicator is clearly defined.
- The data collection methodology and data collection tools for the indicator data are clearly stated.
- The data collection frequency is clearly defined.

[90] Based on An Introduction to Indicators. UNAIDS Monitoring and Evaluation Fundamental Series, January 2010.

- Any relevant subgroups that collected data can be separated into in order to more precisely understand and analyze the findings are clearly defined.
- There are guidelines to interpret and use data from this indicator.
- The strengths and weaknesses of the indicator and the challenges in it use are identified.
- Relevant sources of additional information on the indicator are cited.

Indicators should always have a proven track record (i.e. demonstrated performance in field-testing or operational use) before they are broadly deployed. It is impossible to underestimate the value of a proven track record. Most importantly, it prevents the allocation of resources on indicators that cannot or will not provide useful data.

What Makes a Good Indicator

Good indicators are:

- **Action focused.** Indicators should lead to action. If key informants cannot imagine what to do with the data from an indicator, then it probably isn't a good indicator.
- **Important.** Key informants should agree that the indicator and the data it will generate make a relevant and significant contribution to determining how to effectively respond to the outcome.
- **Measurable.** Not only must the data collection methodology be defined it must also be feasible to collect the data.
- **Simple.** There are very few indicators if any that are perfect. Rather than pursue the perfect indicator, it is much better to identify good, simple indicators that provide data that can be put to use.

Critical Success Factors

Based on the best practices research and application of our own experiences, MNP developed the following critical success factors for the Department's consideration:

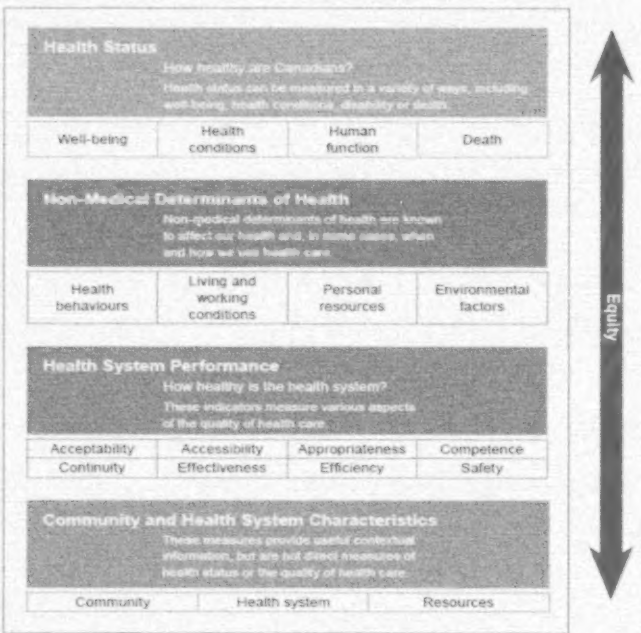
- **Keep it Simple** – Start small with performance measurement and develop over time. This will improve the probability of success and the ability to build off that success.
- **Anchor with Standards and Guidelines** – Use peer reviewed standards and/or guidelines as an anchor or benchmark for performance measurement.
- **Focus on Health Outcomes and System Performance** – Focus on health system performance measurement and health outcomes rather than health system processes.
- **Use Relevant Performance Measures** – Report on a mix of measures that are relevant to and reflective of the health system.
- **Availability of Data** – The ability to collect data that will inform performance measures is the driving force behind the feasibility of what can and cannot be reported.
- **Consistent Data Collection and Analysis** – Consistent data collection and analysis improves the quality of the data used for reporting. It is important to have confidence in the data being reported. Some jurisdictions analyze and manage data at the department of ministry level to ensure consistency and quality.
- **Communication** – Communication with key informants during the development and implementation of the performance measurement strategy is important. Buy-in and utilization of the strategy will improve if key informants are informed of the reasons for the strategy during the development stage. Ongoing communication and reporting to key informants is also required after implementation of the strategy to maintain buy-in and participation.

CIHI Sample Performance Measurement Framework

The Canadian Institute for Health Information (CIHI), in collaboration with Statistics Canada, publishes an annual 'Health Indicators' report. The report contains performance measures that assist in assessing the health of Canadians and the health of the Canadian health system. 'Health Indicators 2012', the most recent version of the report and the 13th in the series, includes updates on more than 40 measures for Canadian regions.

Each of the performance measures included in the 2012 report is grouped into one of the five dimensions of the Health Indicator Framework developed by CIHI and Stats Canada. This framework has been internationally recognized and is shown below.

Health Indicator Framework developed by CIHI and Health Canada[91]


Health Status
How healthy are Canadians?
Health status can be measured in a variety of ways, including well-being, health conditions, disability or death.
Well-being
Health conditions
Human function
Death
Non-Medical Determinants of Health
Non-medical determinants of health are known to affect our health and, in some cases, when and how we use health care.
Health behaviours
Living and working conditions
Personal resources
Environmental factors
Health System Performance
How healthy is the health system?
These indicators measure various aspects of the quality of health care.
Acceptability
Accessibility
Appropriateness
Competence
Continuity
Effectiveness
Efficiency
Safety
Community and Health System Characteristics
These measures provide useful contextual information, but are not direct measures of health status or the quality of health care.
Community
Health system
Resources
Equity

CIHI recently started working on a Health System Performance reporting initiative. The initiative will be completed over a three year period from 2012 to 2015 and has four key objectives:

- To provide structured and coordinated pan-Canadian reporting on health system performance that is tailored to the information needs of different audiences, including the general public, provincial health ministries, regional health authorities and health care facilities;
- To produce analytical tools and products that support provincial and territorial health system improvement priorities;
- To work health system partners to build capacity for using and understanding performance measurements and tools; and

[91] Taken from the 'Health Indicators 2012' report.

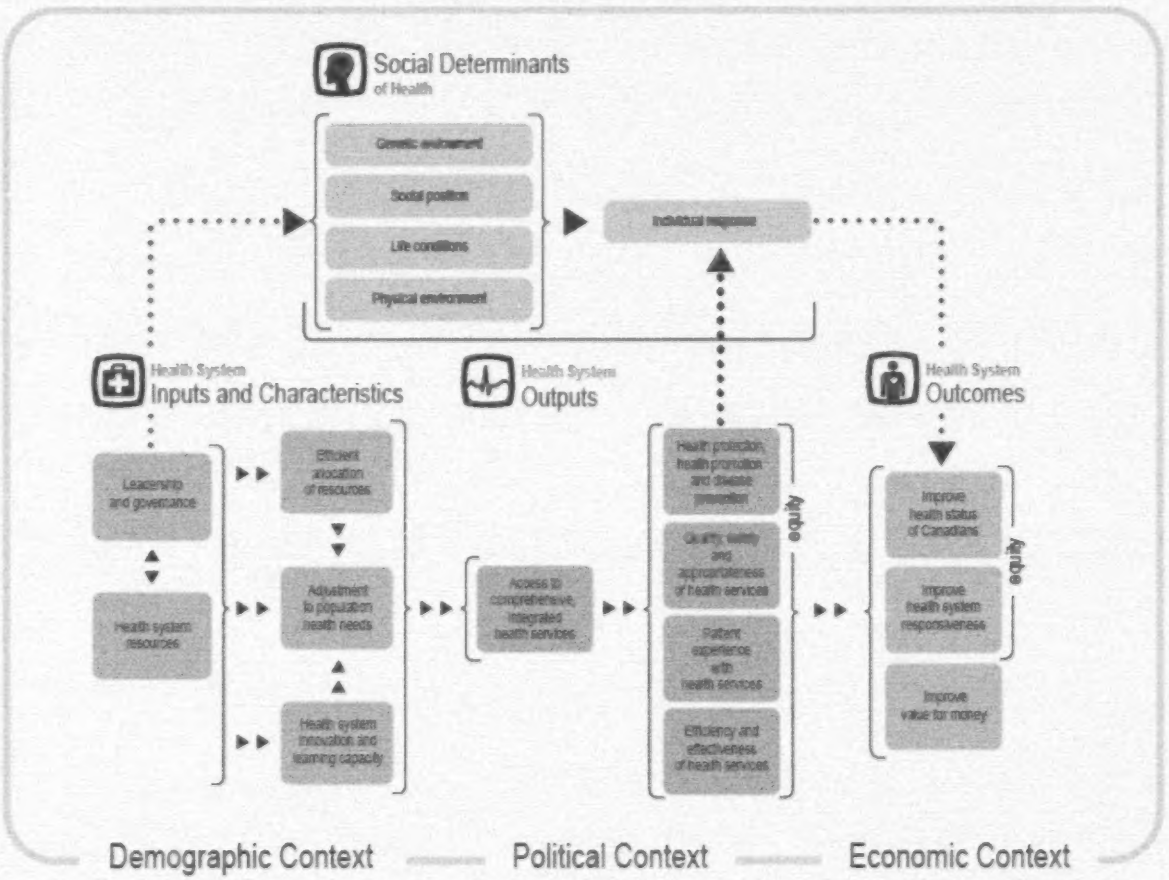
- To reduce "indicator chaos" in the health system by working with partners to identify which health indicators are most important, how they relate to each other, and how they can best support improvements to health care and the health of Canadians.

The initiative has five main work streams including:

- Health system performance measurement framework;
- Health system performance interactive public reporting;
- Integrated analytical environment;
- Research and analysis; and
- Capacity building.

CIHI has developed a new framework for measuring health system performance. The framework builds on the previous framework developed by CIHI and Stats Canada. The new framework has four main quadrants including health system inputs, health system outputs, social determinants of health and health system outcomes. The framework also shows the relationship between each quadrant.

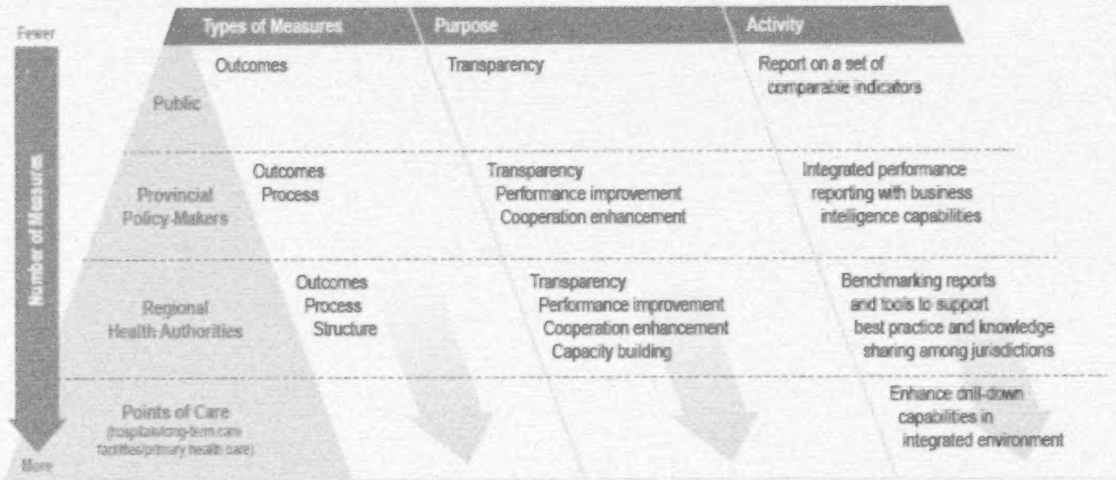
New CIHI Framework for Measuring Health System Performance[92]



[92] Based on the document titled 'Enhancing Pan-Canadian Health System Performance Reporting at CIHI'. This document was provided to MNP by CIHI.

Under this initiative, CIHI will also develop interactive websites that have a focused set of cascading metrics that are meaningful and to useful to different audiences . CIHI recognizes that different audiences are interested in different aspects of health system performance and requires different levels of information.

CIHI Proposed Performance Measurement Reporting by Audience Type



Appendix C

Assumptions Underlying Home and Community Care Service Provider Mix Projections

Estimate of Percentage of HCC Clients aged 60+ by HSSA

HSSA	55 and Older	65 and Older	60 and Older Estimate*
Beaufort-Delta	81%	68%	74%
Dehcho	83%	68%	75%
Fort Smith	90%	72%	81%
Hay River	69%	51%	60%
Sahtu	88%	81%	85%
Tlicho	88%	79%	83%
Yellowknife	61%	36%	48%

* Calculated based on the average of the percent of HCC clients aged 55 plus and percent of clients aged 65 plus. Example, for BDHSSA, 60 plus = (81% + 68%)/2 = 74%.

Ratio of 60 plus population in HCC

HSSA	(A) Number HCC Clients 2012/2013	(B) % HCC Clients 60 and Older	(C) 2011 Population Aged 60 Plus	(A X B)/C Ratio of 60 plus population in HCC
Beaufort-Delta	351	74%	767	0.3
Dehcho	320	75%	356	0.7
Fort Smith	121	81%	354	0.3
Hay River	277	60%	510	0.3
Sahtu	143	85%	240	0.5
Tlicho	99	83%	227	0.4
Yellowknife	760	48%	1,674	0.2

The HCC client numbers are based on Healthsuite data. There was some concern regarding the accuracy of this data. Accordingly, the accuracy of the calculations is subject to the same degree of error plus the degree of error from having to use different age brackets for the population projections and the breakdown of HCC clients.

Population Projections for the 60 plus Age Demographic

HSSA	2011	2016	2021	2026	2031
Beaufort-Delta	767	920	1,065	1,249	1,303
Dehcho	356	460	538	642	747
Fort Smith	354	431	487	543	575
Hay River	510	651	824	930	933
Sahtu	240	310	393	489	494
Tlicho	227	272	319	347	389
Yellowknife	1,674	2,552	3,427	4,025	4,280

Projected Number of Clients in HCC

These projections assume that the growth in the number of HCC clients will be driven by the growth of the 60 plus population in the NWT. The number of HCC clients under the age of 60 was assumed to remain static throughout the projection period, based on the low projected growth for this age demographic. The table below provides the projected number of HCC clients in each HSSA.

HSSA	2012/ 2013	2016	2021	2026	2031
Beaufort-Delta	351	403	452	514	533
Dehcho	320	390	443	513	584
Fort Smith	121	142	158	173	182
Hay River	277	323	379	414	415
Sahtu	143	178	220	269	272
Tlicho	99	115	132	142	158
Yellowknife	760	951	1,142	1,272	1,328

A sample calculation for the projected number of HCC clients in the BDHSSA in 2016 is provided below:

(A) Number HCC Clients 2012/2013	(B) % HCC Clients below 60	(C) Projected 60 Plus Population in 2016	(D) Ratio of 60 plus population in HCC	(A x B) + (C x D) Projected Number of HCC Clients
351	26%	920	0.3	403

This calculation was carried out for each HSSA based on the population projections for those aged 60 plus for 2016, 2021, 2026 and 2031.

Projected number of FTE Nursing Staff

HSSA	2013	2016	2021	2026	2031
Beaufort-Delta	3.7	4.3	4.8	5.5	5.6
Dehcho	3.4	4.1	4.7	5.4	6.2
Fort Smith	1.3	1.5	1.7	1.8	1.9
Hay River	2.9	3.4	4.0	4.4	4.4
Sahtu	1.5	1.9	2.3	2.9	2.9
Tlicho	1.0	1.2	1.4	1.5	1.7
Yellowknife	8.1	10.1	12.1	13.5	14.1

A sample calculation for the projected number of FTE HCC Nursing in the BDHSSA in 2016 is provided below:

(A) Ratio of Nursing Staff/100 HCC Clients in NWT	(B) Projected Number of HCC Clients	A x (B/100) Projected FTE Nurses
1.06	403	4.3

This calculation was carried out for each HSSA based the number of HCC clients in 2012/2013 and the projected number of HCC clients for 2016, 2021, 2026 and 2031.

Projected number of FTE HSW Staff

HSSA	2013	2016	2021	2026	2031
Beaufort-Delta	8.7	10.0	11.3	12.8	13.3
Dehcho	8.0	9.7	11.0	12.8	14.5
Fort Smith	3.0	3.5	3.9	4.3	4.5
Hay River	6.9	8.0	9.4	10.3	10.3
Sahtu	3.6	4.4	5.5	6.7	6.8
Tlicho	2.5	2.9	3.3	3.5	3.9
Yellowknife	18.9	23.7	28.4	31.7	33.1

A sample calculation for the projected number of FTE HSWs in the BDHSSA in 2016 is provided below:

(A) Ratio of HSWs Staff/100 HCC Clients in NWT	(B) Projected Number of HCC Clients	A x (B/100) Projected FTE HSWs
2.49	403	10.0

This calculation was carried out for each HSSA based the number of HCC clients in 2012/2013 and the projected number of HCC clients for 2016, 2021, 2026 and 2031.

Appendix D

Manitoba Health Guidelines for Home Care Tasks

Manitoba Health provided the standard time allocations per task. The regional health authorities use these time allocations as a guideline for service delivery. The time allocations are adjusted based on client specific needs and travel times.

Manitoba Health Time Allocations by Task

Task	Standard Time Allocation
Assistance with a bath tub	25 minutes
Medication ensure	5 to 10 minutes
AM care and breakfast	25 minutes
AM care	20 minutes
HS care	20 minutes
Don/Doff compression stockings	15 minutes
Meal health and serve	20 minutes
Household maintenance and laundry	120 minutes
Household maintenance only	75 minutes
Laundry only (grouped in a block)	25 minutes
Bulk meal preparation	120 minutes